

**All Documents:**

Comment: Change the word Ombudsman to Ombudsperson

**Document: NTDSNPANOCY202407202022**

**Section: Instructions to Health Plans**

Comment:

We suggest adding direction in this area to use state specific Complaint and Language Block per guidance issued by the State. This addition will help to ensure plans don't overlook this important enrollee focused language.

**Section: B. Reviewing your Medicare and [Insert name of Medicaid program] coverage for next year**

Comment:

This section appears to be redundant to section G2. We suggest removing. If the decision is to keep this section, we suggest adding additional instructions. For example, "Plans may insert state-specific Medicaid enrollment options as applicable". The additional instructions will serve to clarify the intent of this section so it is adding additional information for the enrollee.

**Document: NTDNSPCH2CY202407202022**

**Section G: [Insert State-specific name for ombudsman program]**

Comment: In the table under Website, there seems to be a California-specific web link. We believe this may be an error.

## Chapter 5: Getting your outpatient prescription drugs

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### Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and *[Insert name of Medicaid program]*. *[Plans with no cost sharing, delete the next sentence.]* **Chapter 6** of your *Member Handbook* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

We also cover the following drugs, although they are not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please refer to Chapter 5, Section F "If you are in a Medicare-certified hospice program."

### Rules for our plan's outpatient drug coverage

*[If coverage includes Medicaid drugs, please add language as needed for Medicaid.]* We usually cover your drugs as long as you follow the rules in this section.

You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). *[Plans may modify or delete the next sentence as appropriate.]* It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists *[insert as applicable: or any similar Medicaid lists]*.

You generally must use a network pharmacy to fill your prescription.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "Drug List" for short.

- If it is not on the Drug List, we may be able to cover it by giving you an exception.
- Refer to Chapter 9 *[insert reference, as applicable]* to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration or supported by certain medical references. Your doctor may be able to help identify medical references to support the requested use of the prescribed drug. *[Plans should add definition of "medically accepted indication" as appropriate for Medicaid-covered drugs and items.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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## A. Getting your prescriptions filled

### A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website or contact Member Services *[insert if applicable: or your care coordinator]*.

### A2. Using your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy bills us for *[plans with cost-sharing, insert: our share of the cost of]* your covered prescription drug. *[Plans with no cost-sharing, delete the next sentence:]* You may need to pay the pharmacy a copay when you pick up your prescription.

If you don't have your plan ID card with you when you fill your prescription, ask the pharmacy to call us to get the necessary 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. Then you can ask us to pay you back *[insert if the plan has cost-sharing: for our share]*. **If you can't pay for the drug, contact Member Services right away.** We will do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of your *Member Handbook*.
- If you need help getting a prescription filled, contact Member Services *[insert if applicable: or your care coordinator]*.

### A3. What to do if you change your network pharmacy

*[Plans in which members do not need to take any action to change their pharmacies may delete the following sentence.]* If you change pharmacies and need a prescription refill, you can *[insert as applicable: either ask to have a new prescription written by a provider or]* ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services *[insert if applicable: or your care coordinator]*.

### A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services *[insert if applicable: or your care coordinator]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy. *[Plans may insert additional information about home infusion pharmacy services in the plan's network.]*
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services. *[Plans may insert additional information about LTC pharmacy services in the plan's network.]*
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies. *[Plans may insert additional information about I/T/U pharmacy services in the plan's network.]*
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services *[insert if applicable: or your care coordinator]*.

## A6. Using mail-order services to get your drugs

*[Plans that do not offer mail-order services, replace the information in this section with the following sentence: Our plan does **not** offer mail-order services.]*

*[Include the following information only if your mail-order service is limited to a subset of all formulary drugs, adapting terminology as needed: For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition.] [Insert if plan marks mail-order drugs in formulary: Drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List.] [Insert if plan marks non-mail-order drugs in formulary: Drugs **not** available through our plan's mail-order service are marked with *[plans should indicate how these drugs are marked]* in our Drug List.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Our plan's mail-order service *[insert as appropriate: allows or requires]* you to order *[insert as appropriate: at least a <number of days>-day supply of the drug and no more than a <number of days>-day supply or up to a <number of days>-day supply or a <number of days>-day supply]*. A <number of days>-day supply has the same copay as a one-month supply.

### Filling prescriptions by mail

To get *[insert if applicable: order forms and]* information about filling your prescriptions by mail, *[insert instructions]*.

Usually, a mail-order prescription arrives within <number of days> days. *[Insert plan's process for members to get a prescription if the mail-order is delayed.]*

### Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

#### 1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

*[Plans should include the appropriate information below from the following options, based on (1) whether the plan will automatically process new prescriptions consistent with the policy described in the December 12, 2013, CMS memorandum entitled "Clarification to the 2014 Policy on Automatic Delivery of Prescriptions," and 2016 Final Call Letter and (2) whether the plan offers an optional automatic refill program consistent with the policy described in the 2020 Final Call Letter. Plan sponsors who provide automatic delivery through retail or other non-mail means have the option to either add or replace the word "ship" with "deliver" as appropriate.]*

*[For new prescriptions received directly from health care providers, insert one of the following two options.]*

*[Plan sponsors that do not automatically process new prescriptions from provider offices, insert the following:]*

#### 2. New prescriptions the pharmacy gets from your provider's office

After the pharmacy gets a prescription from a health care provider, it contacts you to find out if you want the medication filled immediately or at a later time.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allows you to stop or delay the order before *[plans with cost sharing for drugs, insert: you are billed and]* it is shipped.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

*[Plan sponsors that **do** automatically process new prescriptions from provider offices, insert the following:]*

## 2. New prescriptions the pharmacy gets from your provider's office

The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by *[insert instructions]*.

*[Plans with no cost sharing for drugs, delete the following sentence:]* If you get a prescription automatically by mail that you do not want, and you were not contacted to find out if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, contact us by *[insert instructions]*.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before *[plans with cost sharing for drugs, insert: you are billed and]* it is shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by *[insert instructions]*.

*[For refill prescriptions, insert one of the following two options.]*

*[Plans that **do not** offer a program that automatically processes refills, insert the following:]*

## 3. Refills on mail-order prescriptions



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

For refills, contact your pharmacy *[insert recommended number of days]* days before your current prescription will run out to make sure your next order is shipped to you in time.

*[Plans that do offer a program that automatically processes refills, insert the following:]*

### 3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program *[optional: called <name of auto refill program>]*. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy *[insert recommended number of days]* days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program *[optional: insert name of auto refill program instead of “our program”]* that automatically prepares mail-order refills, contact us by *[insert instructions]*.

*[All plans offering mail-order services, insert the following:]*

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. *[Insert instructions on how members should provide their communication preferences.]*

## A7. Getting a long-term supply of drugs

*[Plans that do not offer extended-day supplies, replace the information in this section with the following sentence: Our plan does not offer long-term supplies of drugs.]*

You can get a long-term 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. *[Insert if applicable: When you get a long-term supply of drugs, your copay may be lower.]*

*[Delete if the plan does not offer extended-day supplies through network pharmacies.]* Some network pharmacies allow you to get a long-term supply of maintenance drugs. A <number of days>-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call *[insert if applicable: your care coordinator or]* Member Services for more information.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Delete if plan does not offer mail-order service.] [Insert as applicable: For certain kinds of drugs, you or You] can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** [insert reference, as applicable] to learn about mail-order services.*

### **A8. Using a pharmacy not in our plan's network**

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. *[Insert as applicable: We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.]*

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

*[Plans should insert a list of situations when they cover prescriptions out of the network (e.g., during a declared disaster) and any limits on their out-of-network policies (e.g., day supply limits, use of mail-order during extended out-of-area travel, authorization or plan notification).]*

In these cases, check with *[insert if applicable: your care coordinator or]* Member Services first to find out if there's a network pharmacy nearby.

### **A9. Paying you back for a prescription**

*[Plans may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]* If you must use an out-of-network pharmacy, you must generally pay the full cost *[plans with cost-sharing, insert: instead of a copay]* when you get your prescription. You can ask us to pay you back *[plans with cost-sharing, insert: for our share of the cost]*.

To learn more about this, refer to **Chapter 7** of your *Member Handbook*.

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## **B. Our plan's Drug List**

We have a *List of Covered Drugs*. We call it the "Drug List" for short.

We select the drugs on the Drug List with the help of a team of doctors and pharmacists. The Drug List also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's Drug List when you follow the rules we explain in this chapter.

*[Plans that offer indication-based formulary design must include: If we cover a drug only for some medical conditions, we clearly identify it on our Drug List and in Medicare Plan Finder along with the specific medical conditions covered.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under *[Insert name of state Medicaid program]*.

*[Insert either of the two sentences: "Our Drug List includes brand name drugs and generic drugs." OR "Our Drug List includes brand name drugs, generic drugs, and biosimilars."]*

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

Generic drugs have the same active ingredients as brand name drugs. *[Insert if applicable: Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars.]* Generally, generic drugs *[Insert if applicable: and biosimilars]* work just as well as brand-name drugs *[Insert if applicable: or biological products]* and usually cost less. There are generic drug substitutes *[Insert if applicable: or biosimilar alternatives]* available for many brand name drugs *[Insert if applicable: and some biological products]*. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

## B2. How to find a drug on our Drug List

To find out if a drug you take is on our Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit our plan's website at <web address>. The Drug List on our website is always the most current one.
- Call *[insert if applicable: your care coordinator or]* Member Services to find out if a drug is on our Drug List or to ask for a copy of the list.

*[Plans may insert additional ways to find out if a drug is on the Drug List.]*

## B3. Drugs not on our Drug List

We don't cover all prescription drugs. Some drugs are not on our Drug List because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List.

*[Plans should remove or modify language regarding benefit exclusions when the benefits are covered by the plan under the Medicaid program.]*

**Commented [HD1]:** This statement will be an issue for D-SNPs in California, since outpatient drug benefits are carved-out of Medi-Cal (Medicaid) managed care organizations and administered directly by the State.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Our plan does not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your *Member Handbook* for more information about appeals.

**Commented [HD2]:** It is not feasible to list every excluded drug. Is that what CMS is expecting here?

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and *[insert name of state-specific Medicaid program]* drugs) cannot pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the Food and Drug Administration (FDA) or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or *[Insert name of Medicaid program]* cannot cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Outpatient drugs made by a company that says you must have tests or services done only by them

**Commented [HD3]:** CMS should remove erectile dysfunction drugs from this list, since plans *can* cover these drugs *outside* of Part D. Keeping this would confuse beneficiaries who *do* have that coverage.

#### **B4. Drug List** *[Plans that do not have cost sharing in any tier may omit: cost sharing] tiers*

Every drug on our Drug List is in one of <number of tiers> *[Plans that do not have cost sharing in any tier may omit: cost-sharing] tiers*. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter (OTC) drugs). *[Plans that do not have cost sharing in any tier may omit the following sentence: In general, the higher the cost-sharing tier, the higher your cost for the drug.]*

*[Plans must briefly describe each tier (e.g., Cost-sharing Tier 1 includes generic drugs, or for plans with no cost sharing in any tier, Tier 1 includes generic drugs). Plans must ensure the tier label or description of the types of drugs on each tier is consistent with guidance regarding*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



*generic tier labels in the 2016 Final Call Letter. Indicate which is the lowest tier and which is the highest tier.]*

To find out which *[Plans that do not have cost sharing in any tier may omit: cost-sharing]* tier your drug is in, look for the drug on our Drug List.

**Chapter 6** of your *Member Handbook* tells the amount you pay for drugs in each *[Plans that do not have cost sharing in any tier may omit: cost sharing]* tier.

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## C. Limits on some drugs

For certain prescription drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

**If there is a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug.** For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, ask us to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

*[Plans should include only the forms of utilization management the plan uses. Plans delete any they don't use and renumber the list accordingly.]*

### 1. Limiting use of a brand name drug when a generic version is available

Generally, a generic drug works the same as a brand name drug and usually costs less. *[Insert as applicable: In most cases, if or If]* there is a generic version of a brand name drug available, our network pharmacies give you the generic version.

- We usually do not pay for the brand name drug when there is an available generic version.
- However, if your provider *[insert as applicable: told us the medical reason that the generic drug won't work for you or wrote "No substitutions" on your prescription for a brand name drug or told us the medical reason that the generic drug or other covered drugs that treat the same condition will work for you]*, then we cover the brand name drug.
- *[Plans that offer all drugs at \$0 cost-sharing, delete the following sentence:]* Your copay may be greater for the brand name drug than for the generic drug.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## 2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from our plan before you fill your prescription. If you don't get approval, we may not cover the drug.

## 3. Trying a different drug first

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A does **not** work for you, then we cover Drug B. This is called step therapy.

## 4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services or check our website at <web address>. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to Chapter 9 of the *Member Handbook*.

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## D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our Drug List. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above [\[insert reference, as applicable\]](#), some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

### D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our Drug List or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**To get a temporary supply of a drug, you must meet the two rules below:**

1. The drug you've been taking:
  - Is no longer on our Drug List **or**
  - Was never on our Drug List **or**
  - Is now limited in some way.
2. You must be in one of these situations:
  - *[Plans omit this scenario if the plan allows current members to ask for formulary exceptions in advance for the following year. Plans omit this scenario if the plan was not operating in the prior year.]* You were in our plan last year.
    - We cover a temporary supply of your drug **during the first *[insert time period (must be at least 90 days)]* days of the calendar year.**
    - This temporary supply is for up to *[insert supply limit (must be the number of days in plan's one-month supply)]* days.
    - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of *[insert supply limit (must be the number of days in plan's one-month supply)]* days of medication. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
  - You are new to our plan.
    - We cover a temporary supply of your drug **during the first *[insert time period (must be at least 90 days)]* days of your membership in our plan.**
    - This temporary supply is for up to *[insert supply limit (must be the number of days in plan's one-month supply)]* days.
    - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of *[insert supply limit (must be the number of days in plan's one-month supply)]* days of medication. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- You have been in our plan for more than *[insert time period (must be at least 90 days)]* days, live in a long-term care facility, and need a supply right away.
  - We cover one *[insert supply limit (must be at least a 31-day supply)]*-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - *[If applicable, plans insert their transition policy for current members with changes to their level of care.]*

## D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

**OR**

- Ask for an exception.

You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our Drug List or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

*[Plans that do not allow current members to ask for an exception prior to the beginning of the following contract year may omit this paragraph.]*

## D3. Asking for an exception

If a drug you take will be taken off our Drug List or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you need help asking for an exception, contact Member Services *[insert if applicable: or your care coordinator]*.

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## E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our Drug List during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year** unless:

- A new, cheaper drug comes on the market that works as well as a drug on our Drug List now, **or**
- We learn that a drug is not safe, **or**
- A drug is removed from the market.

To get more information on what happens when our Drug List changes, you can always:

- Check our current Drug List online at <web address> **or**
- Call Member Services at the number at the bottom of the page to check our current Drug List.

Some changes to our Drug List happen **immediately**. For example:

- *[Plans that otherwise meet all requirements and want the option to immediately replace brand name drugs with their generic equivalents must provide the following advance general notice of changes: **A new generic drug becomes available.** Sometimes, a new generic drug comes on the market that works as well as a brand name drug on our Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug stays the same *[insert if applicable, for example, if the plan's Drug List has differential cost-sharing for some generics: or will be lower.]**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we send you information about the specific change we made once it happens.
- You or your provider can ask for an “exception” from these changes. We send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of your *Member Handbook* for more information on exceptions.]
- **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug’s manufacturer takes a drug off the market, we take it off our Drug List. If you are taking the drug, we tell you. *[Plans include information advising members what to do after they are notified (e.g., contact the prescribing doctor, etc.).]*

**We may make other changes that affect the drugs you take.** We tell you in advance about these other changes to our Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- *[Plans that want the option to immediately substitute a new generic drug, insert: We add a generic drug that is not new to the market and*
  - Replace a brand name drug currently on our Drug List **or**
  - Change the coverage rules or limits for the brand name drug.]
- *[Plans that are not making immediate generic substitutions insert: We add a generic drug and*
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.]

When these changes happen, we:

- Tell you at least 30 days before we make the change to our Drug List **or**
- Let you know and give you a *[insert supply limit (must be at least the number of days in the plan’s one-month supply)]*-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on our Drug List you can take instead **or**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you should ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

**We may make changes to drugs you take that do not affect you now.** For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally do not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking *[insert if applicable: , increase what you pay for the drug,]* or limit its use, then the change does not affect your use of the drug *[insert if applicable: or what you pay for the drug]* for the rest of the year.

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## F. Drug coverage in special cases

### F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you are admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your prescription drugs during your stay. You will not pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

*[Plans with no cost-sharing, delete this paragraph:]* To learn more about drug coverage and what you pay, refer to **Chapter 6** of your *Member Handbook*.

### F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has their own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not or if you need more information, contact Member Services.

### F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug that your hospice does not cover because it is not related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of your *Member Handbook* for more information about the hospice benefit.

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## G. Programs on drug safety and managing drugs

### G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- May not be needed because you take another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we work with your provider to correct the problem.

### G2. Programs to help you manage your drugs

*[If plan has more than one medication therapy management program update language to reflect this.]* Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

Then, they will give you:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you do not want to be in the program, let us know, and we will take you out of it.

If you have questions about these programs, contact Member Services [\[insert if applicable: or your care coordinator\]](#).

### G3. Drug management program for safe use of opioid medications

Our plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid [\[insert if applicable: or benzodiazepine\]](#) medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications from [\[insert: a certain pharmacy or certain pharmacies\]](#) and/or from [\[insert: a certain doctor or certain doctors\]](#)
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter explains the limitations we think should apply.

**You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know.** If we decide to limit your coverage for



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization. To learn more about appeals and the Independent Review Organization, refer to **Chapter 9** of your *Member Handbook*.)

The DMP may not apply to you if you:

- Have certain medical conditions, such as cancer or sickle cell disease,
- Are getting hospice, palliative, or end-of-life care, **or**
- Live in a long-term care facility.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Section/Title            | Commentor                  | Functional Area | Comment(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------|----------------------------|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| General question         | Susan Poosa, Leslie Wilson | EOC             | We would like to confirm if the option to use new EOC and ANOC templates only applies to exclusively aligned HIDE and exclusively aligned FIDE plan or does it apply to other types of D-SNPs as well? When must the states declare that they opt to use the new templates instead of the standard D-SNPs EOC/ANOC models? What is CMS's timeline in communicating to MA organizations the states that require the use of these ineegrated templates and in releasing the final templates for use? |
| Throughout               | Nicole Haider              | EOC             | To ensure ease in implementation of the final Member handbook, please ensure the models formatting is correct, especially when updating the Table of Contents.                                                                                                                                                                                                                                                                                                                                     |
| Throughout               | Nicole Haider              | EOC             | When using acronymns, the words should be written in all capital letters according to grammar rules, then parentheses in all caps (ex: Health Risk Assessment (HRA), Prior Authorization (PA))                                                                                                                                                                                                                                                                                                     |
| Chapter 1, Section B     | Nicole Haider              | EOC             | 2nd bullet point: "Medicare and the <i>State</i> of ..." The word "state" should be lowercase as it is not a proper noun. It would be capitalized if it said Illinois State (which is a proper noun).                                                                                                                                                                                                                                                                                              |
| Chapter 1, Section E     | Nicole Haider              | EOC             | last paragraph - suggest explaining definition of "deeming period" for better understanding                                                                                                                                                                                                                                                                                                                                                                                                        |
| Chapter 1, Section H     | Nicole Haider              | EOC             | misspelling: "If you already enrolled and are getting help form one of these programs" - should be "from, not "form"                                                                                                                                                                                                                                                                                                                                                                               |
| Chapter 1, Section J     | Nicole Haider              | EOC             | Member ID Card is not a defined term so "card" should be lowercase.                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Chapter 2 and throughout | Nicole Haider              | EOC             | The small writing above charts should be removed (unable to decipher what is written)                                                                                                                                                                                                                                                                                                                                                                                                              |
| Chapter 2, Section I     | Nicole Haider              | EOC             | Suggest using acronymn for ESRD                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Chapter 3, Section B     | Nicole Haider              | EOC             | Suggest using "provided" instead of "furnished" in bullet point beginning with, "•You must get your care from network providers "                                                                                                                                                                                                                                                                                                                                                                  |
| Chapter 3, Section I3    | Nicole Haider              | EOC             | Lowercase governor and president as both are common nouns.                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Chapter 3, Section J1    | Nicole Haider              | EOC             | Last paragraph: Suggest change to 2nd sentence for clarity. Either: "If you go over the limit," Or “If you use services over the benefit limit,”                                                                                                                                                                                                                                                                                                                                                   |
| Chapter 4, Section A     | Nicole Haider              | EOC             | 2nd paragraph: missing the word, "you". "For some services, are charged an out-of-pocket cost called a copay."                                                                                                                                                                                                                                                                                                                                                                                     |
| Chapter 4, Section C     | Nicole Haider              | EOC             | bullet with apple icon: It reads better, "You will find this apple next to preventive services in the Benefits Chart."                                                                                                                                                                                                                                                                                                                                                                             |
| Chapter 4, Section D     | Nicole Haider              | EOC             | Colorectal cancer screening: lowercase colonoscopy, Family planning services: lowercase contraception, Health and wellness education programs: misspelling of "fitness" , Hospice care: capitalize Member Services, Medicare Part B prescription drugs (continued) - remove the duplicate word "not" , Outpatient rehabilitation services: misspelling of Medicaid, Physician/provider services, including doctor’s office visits (continued): suggest using acronymns                             |
| Chapter 5, Section A2    | Nicole Haider              | EOC             | For consistency, Ch1 introduces this as Member ID card.                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Chapter 5, Section F2    | Nicole Haider              | EOC             | Suggest changing for consistency.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Chapter 6, Section B     | Nicole Haider              | EOC             | change pronoun to "its" refers to facility not people                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Chapter 6, Section C1    | Nicole Haider              | EOC             | For consistency, Ch1 introduces this as Member ID card.                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Chapter 6, Section H1    | Nicole Haider              | EOC             | Plan instructions should include plans that have only 1 Tier with no Cost Share. Model should make allowances for those PBPs that would be filed as Defined Standard and would not having a tiering structure and remove all instances to tiering; to include would more than likely cause member confusion as their formulary will have no tiering information.                                                                                                                                   |
| Chapter 7, Section A     | Nicole Haider              | EOC             | change verb "work" to "works"                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Chapter 7, Section A     | Nicole Haider              | EOC             | Capitalize Member Services for consistency.                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Chapter 7, Section B     | Nicole Haider              | EOC             | For consistency, Ch1 introduces this as Member ID card.                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Chapter 7, Section B     | Nicole Haider              | EOC             | suggest adding the word "covered" to make clear only covered services will be reimbursed.                                                                                                                                                                                                                                                                                                                                                                                                          |
| Chapter 7, Section B     | Nicole Haider              | EOC             | Missing the word "for" " you may also call us to ask <u>for</u> payment"                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Chapter 7, Section B     | Nicole Haider              | EOC             | Suggest using "timeframe" instead of "days" as it could be years                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Chapter 8, Section B     | Nicole Haider              | EOC             | suggest using "You" instead of women for gender inclusive language.                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Chapter 8, Section C     | Nicole Haider              | EOC             | remove "to from 3rd paragraph as not needed                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Chapter 8, Section H1    | Nicole Haider              | EOC             | Italicize "Member Handbook"                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Chapter 8, Section I     | Nicole Haider              | EOC             | For consistency, Ch 1 introduces this as Member ID card.                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Chapter 9, Section F5    | Nicole Haider              | EOC             | Italicize "Member Handbook"                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

Regulatory Operations Comment Form

|                       |               |     |                                                                                      |
|-----------------------|---------------|-----|--------------------------------------------------------------------------------------|
| Chapter 9, Section I2 | Nicole Haider | EOC | Suggest putting "Notice of Medicare Non-Coverage" in quotations.                     |
| Chapter 10, Section E | Nicole Haider | EOC | For consistency, Ch 1 introduces this as Member ID card.                             |
| Chapter 12, last page | Nicole Haider | EOC | The small writing above chart should be removed (unable to decipher what is written) |



**RE: Opportunity to Comment on Integrated Annual Notice of Changes and Evidence of Coverage for Dual Eligible Special Needs Plans in Certain States:**

**Email evidence provided for the memo and upload for the link provided in memo.**

**Details below:**

Hi! Just some notes below for our discussion this morning.

**From:** Carla Boyd <[Carla.Boyd@CENTENE.com](mailto:Carla.Boyd@CENTENE.com)>  
**Sent:** Tuesday, October 25, 2022 11:57 AM  
**To:** Mark J. Stolzer <[Mark.J.Stolzer@centene.com](mailto:Mark.J.Stolzer@centene.com)>; Ashley L. Wilson <[Ashley.L.Wilson@centene.com](mailto:Ashley.L.Wilson@centene.com)>  
**Cc:** Jennifer D. Dickens <[Jennifer.Dickens2@CENTENE.COM](mailto:Jennifer.Dickens2@CENTENE.COM)>  
**Subject:** RE: Opportunity to Comment on Integrated Annual Notice of Changes and Evidence of Coverage for Dual Eligible Special Needs Plans in Certain States

Good morning Mark,

I wanted to know if you have any updates regarding the ask from Tyler Rieger?

Thank you,

**From:** Carla Boyd  
**Sent:** Friday, October 7, 2022 3:17 PM  
**To:** Mark J. Stolzer <[Mark.J.Stolzer@centene.com](mailto:Mark.J.Stolzer@centene.com)>; Ashley L. Wilson <[Ashley.L.Wilson@centene.com](mailto:Ashley.L.Wilson@centene.com)>  
**Cc:** Jennifer D. Dickens <[Jennifer.Dickens2@wellcare.com](mailto:Jennifer.Dickens2@wellcare.com)>  
**Subject:** RE: Opportunity to Comment on Integrated Annual Notice of Changes and Evidence of Coverage for Dual Eligible Special Needs Plans in Certain States

Hi Mark,

I apologize for the delay in getting you this information. In my follow-up with Tyler I was able to confirm the following 2023 Final Rules. Please advise if you are able to assist with his questions.

- 2.A.3.2- Capitation for Medicare Cost-Sharing for FIDE SNPs (§ 422.2)
  - 2.A.3.2.II- Ensure this change regarding cost sharing is taken into consideration when developing the 01/01/2025 bids. **Tyler Rieger added:** Ensure communication to downstream teams (e.g. Pharmacy) when SMACs are updated and become effective with \$0 copays if that information is not included in the HPMS submission. Must include a manner to identify the impacted plans or enrollees.
  - **Crissy:** Tracking this as part of the final rule implementation - Actuary to work with Product – this flows into the annual bid cycle and AEP readiness. Requirements will be accounted for however SMAC contracts will not list copays, these would be filed in the bids.
- 2.A.3.3 Scope of Services Covered by FIDE SNPs and HIDE SNPs (§ 422.2 & 422.107)
  - 2.A.3.3.II- Ensure these provisions are taken into consideration when developing the 01/01/2025 bids. **Tyler Rieger added:** Ensure communication to downstream teams (e.g. Pharmacy) when SMACs are updated and become effective with \$0 copays if that information is not included in the HPMS submission. Must include a manner to identify the impacted plans or enrollees.
  - **Crissy:** 2025 Final rule details: "FIDE SNPs required to cover primary care and acute care services (excluding non-emergency medical transportation) and Medicare cost sharing through capitated contracts with State Medicaid agencies, as well as behavioral health services, home health services, and durable medical equipment. HIDE SNPs required to have a capitated contract with the state Medicaid agency and cover, at a minimum, Medicaid LTSS or Medicaid behavioral health services. CMS is allowing limited carve-outs in FIDE SNPs and HIDE SNPs for Medicaid LTSS and behavioral health services if the carve-out applies to a minority of eligible enrollees or constitutes a small part of the total scope of services provided to eligible enrollees."
  - **Crissy:** Anticipate CMS to update the matrix template to include these requirements. States will/have been informed of these requirements and health plans/Product to confirm detail is listed in draft SMACs and/or discussed during state meetings.
- 2.A.4.2 Integrated Member Materials (§ 422.107)
  - 2.A.4.2.I- HPs with exclusively aligned enrollment D-SNPs to work with States to confirm implementation decision/strategy and update SMACs as applicable. **Tyler Rieger added:** Ensure communication of applicable plans to downstream teams (e.g. Pharmacy). Must include a manner to identify the impacted plans or enrollees.
  - **Crissy:** The materials team already creates aligned/integrated materials, no concern here. SMAC matrix template already includes plans to call out exclusive alignment. Currently, all CNC FIDEs have exclusively aligned enrollment with the exception of PA. PA SMAC will need to be updated for 2025 to meet new rule.
- 2.A.5 Definition of Applicable Integrated Plan Subject to Unified Appeals and Grievances (§ 422.561)
  - CMS modified the definition of applicable integrated plan to include coordinated (i.e., non-FIDE or HIDE) D-SNPs affiliated with a Medicare Managed Care Organization and that meet specific provisions. **Tyler Rieger added:**

- Integrated Appeals and Grievances is a misnomer. This applies to initial integrated organization determinations as well.
  - 2.A.5.II- Review SMACs and identify applicable integrated plans impacted by the expanded definition. **Tyler Rieger added:** Ensure communication of applicable plans to downstream teams (e.g. Pharmacy, Med Management, Appeals, Grievances). Must include a manner to identify the impacted plans or enrollees.
  - **Crissy:** New A&G tasks in our SMAC contracts flows through AEP readiness for implementation. CA is our only AIP, I don't believe this will change for CY2024 but more to come as SMAC drafts come in.
- 2.A.7.B (7.B) Requirements to Unify Appeals and Grievances for Applicable Integrated Plans – Enrollee Representatives (§ 422.629)
  - CMS modified the definition of applicable integrated plan to include coordinated (i.e., non-FIDE or HIDE) D-SNPs affiliated with a Medicare Managed Care Organization and that meet specific provisions. **Tyler Rieger added:** Integrated Appeals and Grievances is a misnomer. This applies to initial integrated organization determinations as well.
  - 2.A.5.II- Review SMACs and identify applicable integrated plans impacted by the expanded definition. **Tyler Rieger added:** Ensure communication of applicable plans to downstream teams (e.g. Pharmacy, Med Management, Appeals, Grievances). Must include a manner to identify the impacted plans or enrollees.
  - **Crissy:** Same comment as 2.A.5.
- 2.A.7.B (7.B) Requirements to Unify Appeals and Grievances for Applicable Integrated Plans - Enrollee Representatives (§ 422.629)
  - Clarifies that an enrollee's representative includes any person authorized under state law and permits an assignee of the enrollee and/or provider or entity who has an appealable interest in the proceeding to request an integrated reconsideration. **Tyler Rieger added:** Integrated Appeals and Grievances is a misnomer. The changes to 422.629(l) apply to initial integrated organization determinations and integrated givenaces as well.
  - **Crissy:** Same comment as 2.A.5.
- 2.B MAOs are required to adhere to special access requirements during a disaster or emergency declaration, there must also be a disruption of access to health care in addition to that disaster or emergency declaration. Disruption of access to health care definition: to be an interruption or interference in access to health care in a service area such that the enrollee is unable to access contracted providers or such providers are unable to deliver services, resulting in MA organizations failing to meet the normal prevailing patterns of community health care delivery. CMS will add an explicit 30-day transition period after the end of a disaster or emergency occurs, with MA organizations continuing to adhere to the special access requirements until the transition period ends. **Tyler Rieger Added:** Centene Medicare Operations should have an overarching disaster plan that would communicate to the vairous operational departments (e.g. Pharmacy, Med Management, Claims, etc.) which service areas are impacted, dates of impact, and which special access requirements Centene wants turned. The vairous operational departments could then follow that plan.



Thank you,

**From:** Mark J. Stolzer <[Mark.J.Stolzer@centene.com](mailto:Mark.J.Stolzer@centene.com)>

**Sent:** Friday, September 23, 2022 2:57 PM

**To:** Carla Boyd <[Carla.Boyd@CENTENE.com](mailto:Carla.Boyd@CENTENE.com)>; Ashley L. Wilson <[Ashley.L.Wilson@centene.com](mailto:Ashley.L.Wilson@centene.com)>

**Subject:** RE: Opportunity to Comment on Integrated Annual Notice of Changes and Evidence of Coverage for Dual Eligible Special Needs Plans in Certain States

Hi Carla!

I am not sure what the question is from Tyler.....can you provide a little more detail?

Thank you!

**Mark J. Stolzer**

Manager, Ethics & Compliance

Centene Corporation

Direct: (314) 236-8360 | Ext: 802-7760

Cell: (636) 489-8999

7676 Forsyth Blvd | St. Louis, MO 63105



**From:** Carla Boyd <[Carla.Boyd@CENTENE.com](mailto:Carla.Boyd@CENTENE.com)>

**Sent:** Thursday, September 22, 2022 10:10 AM

**To:** Ashley L. Wilson <[Ashley.L.Wilson@centene.com](mailto:Ashley.L.Wilson@centene.com)>; Mark J. Stolzer <[Mark.J.Stolzer@centene.com](mailto:Mark.J.Stolzer@centene.com)>

**Subject:** FW: Opportunity to Comment on Integrated Annual Notice of Changes and Evidence of Coverage for Dual Eligible Special Needs Plans in Certain States

Good morning Ashley & Mark,

I am hoping you can assist me with a question Tyler Rieger posed. Here is the question...

- I know we cleared up which DSNPs are AIPs for integrated PAs....but do we know which DSNPs fall into the other rules?

Thank you,

**From:** HPMS <[hpms@cms.hhs.gov](mailto:hpms@cms.hhs.gov)>

**Sent:** Tuesday, September 13, 2022 3:04 PM

**To:** Carla Boyd <[Carla.Boyd@CENTENE.com](mailto:Carla.Boyd@CENTENE.com)>

**Subject:** Opportunity to Comment on Integrated Annual Notice of Changes and Evidence of Coverage for Dual Eligible Special Needs Plans in Certain States

**Caution:** Do not click on links or open any attachments unless you recognize  
**External Email** the sender and know the contents are safe. Think before you click!

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Please see the attached memorandum from Kimberly Spalding Bush, Director, Program Alignment Group, Medicare-Medicaid Coordination Office, about the opportunity to comment on the proposed integrated Annual Notice of Changes and Evidence of Coverage for dual eligible special needs plans that are applicable integrated plans.

Please contact the Medicare-Medicaid Coordination Office at [MMCO\\_DSNPOperations@cms.hhs.gov](mailto:MMCO_DSNPOperations@cms.hhs.gov) if you have any questions.

## Chapter 4: Benefits chart

### Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services *[insert if the plan has cost sharing: and how much you pay for each service]*. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

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**If you have questions**, please call <plan name> at <toll-free phone and TTY/TDD numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 1

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## A. Your covered services *[insert if the plan has cost sharing: and your out-of-pocket costs]*

This chapter tells you about services our plan covers *[insert if the plan has cost-sharing: and how much you pay for each service]*. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your *Member Handbook*. *[Insert if applicable: This chapter also explains limits on some services.]*

*[Plans with cost sharing, insert: For some services, are charged an out-of-pocket cost called a copay. This is a fixed amount (for example, \$5) you pay each time you get that service. You pay the copay at the time you get the medical service.]*

*[Plans with **no** cost-sharing for any services described in this chapter, insert: Because you get assistance from *[Insert name of state-specific Medicaid program]*, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of your *Member Handbook* for details about the plan's rules.]*

If you need help understanding what services are covered, call *[insert: your care coordinator and/or Member Services at <phone number(s)>]*.

*[As applicable, plans insert the subsection heading and information below.]*

### A1. During public health emergencies

*[Plans providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describe the coverage and flexibilities here or include general information about the coverage and flexibilities along with any cross references, as applicable. Plans include whether such coverage and flexibilities are contingent upon the duration of the public health emergency, which may or may not last for the entire year. Plans also include any specific contact information, as applicable, where members can get more details.]*

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## B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

**You should never get a bill from a provider for covered services.** If you do, refer to **Chapter 7** of your *Member Handbook* or call Member Services.

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## C. About our plan's Benefits Chart



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans may add references to long-term care or home and community-based services.]*

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them. *[Plans that include an index at the end of the chapter should insert: To find a service in the chart, you can also use the index at the end of the chapter.]*

**We pay for the services listed in the Benefits Chart when the following rules are met.**

*[Plans that do not have cost-sharing, insert: You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.]*

- We provide covered Medicare and *[Insert name of state-specific Medicaid program]* covered services according to the rules set by Medicare and *[Insert name of state-specific Medicaid program]*.
- The services *[Plans may revise as applicable: (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs)]* must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise and use the state-specific definition of “medically necessary” and ensure that it is updated and used consistently in Chapter 12 and throughout member materials.]*
- *[Insert if applicable: You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your *Member Handbook* has more information about using network and out-of-network providers.]*
- *[Insert if applicable: You have a primary care provider (PCP) or a care team that is providing and managing your care. [Plans that do not require referrals, omit the rest of this paragraph:]* In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan’s network. This is called a referral. **Chapter 3** of your *Member Handbook* has more information about getting a referral and when you do **not** need one.]
- *[Insert if applicable: We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need prior authorization (PA) [insert as appropriate: with an asterisk (\*) or with a*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

footnote **or** in bold type *or* in italic type].] *[Insert if applicable: In addition, you must get prior authorization (PA) for the following services not listed in the Benefits Chart: [insert list].]*

- *[Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI)” in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Members with Certain Chronic Conditions**. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [insert if applicable: and/or reduced cost sharing]:*
  - *[List all applicable chronic conditions here.]*
  - *[If offering SSBCI, include information about the process and/or criteria for determining eligibility for SSBCI. Plan must also deliver a written summary of the SSBCI offered to each chronically ill member eligible for SSBCI.]*

Refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.]

- *[Insert as applicable: Most **or** All]* preventive services are free. You find this apple icon next to preventive services in the Benefits Chart.
- *[Insert any additional applicable Medicaid program coverage here such as community supports]*

*[Instructions on completing the Benefits Chart:*

- *For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.*
- *Optional supplemental benefits are not permitted in this chart; optional supplemental benefits should be described in section E.*
- *Include the following where appropriate: Talk to your provider and get a referral.*
- *Plans must include any services provided in excess of the Medicare and Medicaid requirements and identify preventive services with the apple icon.*
- *HMO POS plan types must provide information about which services must be obtained from network providers, which services can be obtained out-of-network under the POS benefit, and any differences in cost sharing for covered services obtained out-of-network under the POS benefit.*

**Commented [WL1]:** The instructions mention SSBCI but do not mention VBID benefits - recommend adding for D-SNPs that file VBID to include the required WHP language.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Plans should clearly indicate which benefits are subject to prior authorization (PA). (This can be done with asterisks, footnotes, bold type, or italic type. Plans must select only one method of indication, describe it in terms easily understandable by members, make the indication and description prominently visible, and use it consistently throughout the document.)*
- *Plans may insert any additional benefit information that is based on the plan's approved benefit package and not already included in the Benefits Chart or in the exclusions section. Plans insert any additional benefits in the chart alphabetically.*
- *Plans must add any Medicaid benefits covered to the chart as instructed by the state. Insert any additional benefits in the chart alphabetically. If directed by the state, include all non-waiver services in the chart and all HCBS waiver services as a separate section after the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed. The remainder of the sections should then be renumbered.*
- *Plans must describe any restrictive policies, limitations, or monetary limits that might affect a member's access to services within the chart.*
- *Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.*
- *Plans should include all non-waiver LTSS in the chart in alphabetical order.*
- *Plans with no cost sharing for any type of service (i.e., no cost sharing at all) may delete the "what you must pay" column from the table. Plans with any type of cost sharing for services, including for pharmacy services, must leave the "what you must pay" column in the table.*
- *Plans offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:*
  - *Deliver to each clinically-targeted member a written summary of those benefits so that such member are notified of the "Uniformity Flexibility" benefits for which they are eligible.*
  - *Update the Benefits Chart to include details, as applicable, about the exact targeted reduced cost sharing amount for each specific service and/or the additional supplemental benefits being offered.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

D. Our plan’s Benefits Chart

*[When a benefit continues from one page to the next, plans enter a blank return before right aligning and inserting at the bottom of the first part of the description: **This benefit is continued on the next page.** At the top of the next page where the benefit description continues, plans enter the benefit name again in bold followed by (continued). Plans may refer to **Durable medical equipment (DME) and related supplies** and other benefits later in this chart as examples. Plans should also be aware that the flow of benefits from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed.]*

*[Plans should modify this section throughout to reflect Medicaid or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medicaid.]*

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay                                               |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
|  | <p><b>Abdominal aortic aneurysm screening</b></p> <p>We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <p><b>Acupuncture</b></p> <p>We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as:</p> <ul style="list-style-type: none"> <li>• lasting 12 weeks or longer;</li> <li>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);</li> <li>• not associated with surgery; <b>and</b></li> <li>• not associated with pregnancy.</li> </ul> <p>In addition, we pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.</p> <p>Acupuncture treatments must be stopped if you don't get better or if you get worse.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p> <b>Alcohol misuse screening and counseling</b></p> <p>We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.</p> <p>If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                       | <p>\$0</p>                                                      |

**Commented [JJ2]:** Janelle Sharp-If a plans supplemental benefit is BETTER than the medicare defined benefit (example Acupuncture) can plan remove the language and add the supplement benefit? Or should the supplement benefit be added to the same section, but under the Medicare benefit? We sometimes offer unlimited acupuncture and had questions on this benefit with the CA EAE DSNP.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | What you must pay                                                 |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
|    | <b>Ambulance services</b><br><br>Covered ambulance services include ground, air (airplane and helicopter), and rotary-wing ambulance services. The ambulance will take you to the nearest place that can give you care.<br><br>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases must be approved by us.<br><br>In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. | \$0                                                               |
|  | <b>Annual wellness visit</b><br><br>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                                                                                                                                                                                                                                                  | \$0                                                               |
|  | <b>Bone mass measurement</b><br><br>We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.<br><br>We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                            | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
|  <b>Breast cancer screening (mammograms)</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>• One baseline mammogram between the ages of 35 and 39 <i>[plans that only cover ages 65 and older should delete]</i></li> <li>• One screening mammogram every 12 months <i>[plans that cover women under 65 should include: for women age 40 and older]</i></li> <li>• Clinical breast exams once every 24 months</li> </ul> <i>[List any additional benefits offered.]</i>                                     | \$0<br><i>[List copays for additional benefits.]</i> |
| <b>Cardiac (heart) rehabilitation services</b><br>We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's <i>[insert as appropriate: referral or order]</i> .<br>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.                                                                                                                                                                                                                                                 | \$0                                                  |
|  <b>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</b><br>We pay for one visit a year, or more if medically necessary, with your primary care provider to help lower your risk for heart disease. During the <i>[insert: visit or visits]</i> , your doctor may: <ul style="list-style-type: none"> <li>• Discuss aspirin use,</li> <li>• Check your blood pressure, <b>and/or</b></li> <li>• Give you tips to make sure you are eating well.</li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><i>[List copays for additional benefits.]</i> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
|  <b>Cardiovascular (heart) disease testing</b><br>We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                         | \$0<br><i>[List copays for additional benefits.]</i>                     |
|  <b>Cervical and vaginal cancer screening</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>For all women: Pap tests and pelvic exams once every 24 months</li> <li>For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months</li> <li><i>[Plans that cover women under 65 must include: For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months]</i></li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><i>[List copays for additional benefits.]</i>                     |
| <b>Chiropractic services</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>Adjustments of the spine to correct alignment</li> </ul> <i>[List any Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.]</i>                                                                                                                                                                                                                                                                                                                         | <i>[List copays.]</i><br><i>[List copays for supplemental benefits.]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
|  <b>Colorectal cancer screening</b><br>For people 50 and older, we pay for the following services: <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema) every 48 months</li> <li>• Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months</li> <li>• DNA based colorectal screening, every 3 years</li> <li>• Screening Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy)</li> <li>• Screening Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months.</li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><i>[List copays for additional benefits.]</i>                            |
| <i>[Include row if applicable and modify to accurately describe the Medicaid and/or supplemental benefit offered.]</i><br><b>Dental services</b><br>Certain dental services, including cleanings, fillings, and dentures, are available through the <i>[insert name of Medicaid program or integrated name]</i> Dental Program.<br><i>[Plans that offer optional supplemental dental benefits insert: Note: Our plan offers additional dental services. Got to Benefits Chart in Section E for more information.]</i>                                                                                                                                                                                                                                 | <i>[If plan offers supplemental benefit, the maximum copay amount is \$10.]</i> |
|  <b>Depression screening</b><br>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                                                                                                                                                                             | \$0<br><i>[List copays for additional benefits.]</i>                            |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                        |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
|  | <p><b>Diabetes screening</b></p> <p>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"><li>• High blood pressure (hypertension)</li><li>• History of abnormal cholesterol and triglyceride levels (dyslipidemia)</li><li>• Obesity</li><li>• History of high blood sugar (glucose)</li></ul> <p>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.</p> <p>Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.</p> <p><a href="#">[List any additional benefits offered.]</a></p> | <p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | What you must pay                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <div data-bbox="154 464 191 506"></div> <div data-bbox="207 470 824 501"><b>Diabetic self-management training, services, and supplies</b></div> <div data-bbox="207 518 773 575"><p>We pay for the following services for all people who have diabetes (whether they use insulin or not):</p></div> <div data-bbox="215 588 799 1218"><ul style="list-style-type: none"><li>• Supplies to monitor your blood glucose, including the following:<ul style="list-style-type: none"><li>○ A blood glucose monitor</li><li>○ Blood glucose test strips</li><li>○ Lancet devices and lancets</li><li>○ Glucose-control solutions for checking the accuracy of test strips and monitors</li></ul></li><li>• For people with diabetes who have severe diabetic foot disease, we pay for the following:<ul style="list-style-type: none"><li>○ One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, <b>or</b></li><li>○ One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)</li></ul></li><li>• In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.</li></ul></div> <div data-bbox="207 1232 568 1260"><a href="#">[List any additional benefits offered.]</a></div> | <div data-bbox="878 470 911 497">\$0</div> <div data-bbox="878 512 1076 569"><a href="#">[List copays for additional benefits.]</a></div> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Durable medical equipment (DME) and related supplies</b></p> <p>Refer to Chapter 12 of your <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).”</p> <p>We cover the following items:</p> <ul style="list-style-type: none"> <li>• Wheelchairs</li> <li>• Crutches</li> <li>• Powered mattress systems</li> <li>• Diabetic supplies</li> <li>• Hospital beds ordered by a provider for use in the home</li> <li>• Intravenous (IV) infusion pumps and pole</li> <li>• Speech generating devices</li> <li>• Oxygen equipment and supplies</li> <li>• Nebulizers</li> <li>• Walkers</li> <li>• Standard curved handle or quad cane and replacement supplies</li> <li>• Cervical traction (over the door)</li> <li>• Bone stimulator</li> <li>• Dialysis care equipment</li> </ul> <p>Other items may be covered.</p> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays, including how they vary for equipment covered by Medicare and Medicaid, if applicable.]</i></p> <p><i>[Include if applicable: Your cost sharing for Medicare oxygen equipment coverage is [insert copay amount or coinsurance percentage], every [insert required frequency of payment].]</i></p> <p><i>[Plans that use a constant cost-sharing structure for oxygen equipment insert: Your cost sharing will not change after being enrolled for 36 months.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay                                                                                                                                                                                                                                                                                                                                                                              |
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| <p><b>Durable medical equipment (DME) and related supplies (continued)</b></p> <p><i>[Plans that do not limit the DME brands and manufacturers that they cover, insert: We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.]</i></p> <p><i>[Plans that limit the DME brands and manufacturers that they cover, insert the following (for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual): With this Member Handbook, we sent you our plan's list of DME. The list tells you the brands and makers of DME that we pay for. You may also find the most recent list of brands, makers, and suppliers on our website at &lt;URL&gt;.</i></p> <p>Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We do not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to our plan and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)</p> <p>If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor may file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is right for your medical condition. For more information about appeals, refer to <b>Chapter 9</b> of your <i>Member Handbook</i>.]</p> | <p><i>[Plans that wish to vary cost sharing for oxygen equipment after 36 months insert details including whether original cost sharing resumes after 5 years and you are still in the plan.] [If cost sharing is different for members who made 36 months of rental payments prior to joining the plan insert: If prior to enrolling in [insert plan name] is [insert cost sharing].]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                                 |
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| <p><b>Emergency care</b></p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> <li>Given by a provider trained to give emergency services, <b>and</b></li> <li>Needed to treat a medical emergency.</li> </ul> <p>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> <li>Serious risk to your health <i>[Plans that cover women under 65 must include: or to that of your unborn child]; or</i></li> <li>Serious harm to bodily functions; <b>or</b></li> <li>Serious dysfunction of any bodily organ or part; <b>or</b></li> <li><i>[Plans that cover women under 65 must include: In the case of a pregnant woman in active labor, when:</i> <ul style="list-style-type: none"> <li>There is not enough time to safely transfer you to another hospital before delivery.</li> <li>A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]</li> </ul> </li> </ul> <p><i>[Also identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.]</i></p> | <p><b>\$0</b></p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, <i>[plans should insert information as needed to accurately describe emergency care benefits: (e.g., you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.)]</i>.</p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay            |
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| <p><i>[If family planning services are covered, plans should modify this as necessary.]</i></p> <p><b>Family planning services</b></p> <p>The law lets you choose any provider for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Family planning exam and medical treatment</li> <li>• Family planning lab and diagnostic tests</li> <li>• Family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring)</li> <li>• Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)</li> <li>• Counseling and diagnosis of infertility and related services</li> <li>• Counseling, testing, and treatment for sexually transmitted infections (STIs)</li> <li>• Counseling and testing for HIV and AIDS, and other HIV-related conditions</li> <li>• Permanent Contraception (You must be age 21 or older to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.)</li> <li>• Genetic counseling</li> </ul> <p>We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:</p> <ul style="list-style-type: none"> <li>• Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)</li> <li>• Treatment for AIDS and other HIV-related conditions</li> <li>• Genetic testing</li> </ul> | <p><i>[List copays.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                                      |
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|  <b>Health and wellness education programs</b><br><i>[These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness and stress management. Describe the nature of the programs here.]</i><br><i>[If this benefit is not applicable, plans should delete this row.]</i>                                                                                                                                                                                                             | <i>[List copays.]</i>                                                  |
| <i>[Plans should modify this section to reflect plan-covered benefits as appropriate.]</i><br><b>Hearing services</b><br>We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.                                                                                                                                                                                                                                                                                                                                                                | <i>[List copays.]</i><br><i>[List copays for additional benefits.]</i> |
| <i>[If this benefit is not applicable, plans should delete this row.]</i><br><b>Help with certain chronic conditions</b><br><i>[Plans that offer targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI),” which members with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits and (as applicable) reduced cost sharing. If offering SSBCI, plans must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package submission.]</i> | <i>[List copays.]</i>                                                  |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay                                               |
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|  <p><b>HIV screening</b></p> <p>We pay for one HIV screening exam every 12 months for people who:</p> <ul style="list-style-type: none"> <li>• Ask for an HIV screening test, <b>or</b></li> <li>• Are at increased risk for HIV infection.</li> </ul> <p>For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><b>Home health agency care</b></p> <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p>Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• 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.)</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> </ul> | <p><i>[List copays.]</i></p>                                    |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                                                                   |
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| <p><b>Home infusion therapy</b></p> <p>Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:</p> <ul style="list-style-type: none"><li>• The drug or biological substance, such as an antiviral or immune globulin;</li><li>• Equipment, such as a pump; <b>and</b></li><li>• Supplies, such as tubing or a catheter.</li></ul> <p>Our plan covers home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"><li>• Professional services, including nursing services, provided in accordance with your care plan;</li><li>• Member training and education not already included in the DME benefit;</li><li>• Remote monitoring; <b>and</b></li><li>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.</li></ul> <p><a href="#">[List any additional benefits offered.]</a></p> | <p><a href="#">[List copays.]</a></p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                                                                                    |
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| <p><b>Hospice care</b></p> <p>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Our plan pays for the following while you get hospice services:</p> <ul style="list-style-type: none"> <li>• Drugs to treat symptoms and pain</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul> <p><b>Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.</b></p> <ul style="list-style-type: none"> <li>• Refer to <b>Section F</b> of this chapter for more information.</li> </ul> <p><b>For services covered by our plan but not covered by Medicare Part A or Medicare Part B:</b></p> <ul style="list-style-type: none"> <li>• Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay <i>[insert as appropriate: our plan's cost-sharing amount or nothing]</i> for these services.</li> </ul> <p><b>For drugs that may be covered by our plan's Medicare Part D benefit:</b></p> <ul style="list-style-type: none"> <li>• Drugs are never covered by both hospice and our plan at the same time. For more information, refer to <b>Chapter 5</b> of your <i>Member Handbook</i>.</li> </ul> <p><b>Note:</b> If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that is <b>not</b> related to your terminal prognosis.</p> <p><i>[Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.]</i></p> | <p><i>[List copays.]</i></p> <p><i>[Include information about cost sharing for hospice consultation services if applicable.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay                                                        |
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|  | <p><b>Immunizations</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Pneumonia vaccine</li><li>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary</li><li>• Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B</li><li>• COVID-19 vaccines</li><li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li></ul> <p>We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to <b>Chapter 6</b> of your <i>Member Handbook</i> to learn more.</p> <p><a href="#">[List any additional benefits offered.]</a></p> | <p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                    |
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| <p><b>Inpatient hospital care</b></p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p><i>[List any restrictions that apply.]</i></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units, such as intensive care or coronary care units</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Needed surgical and medical supplies</li> <li>• Appliances, such as wheelchairs</li> <li>• Operating and recovery room services</li> <li>• Physical, occupational, and speech therapy</li> <li>• Inpatient substance abuse services</li> <li>• In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><b>\$0</b></p> <p>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.</p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay |
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| <p><b>Inpatient hospital care (continued)</b></p> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. <i>[Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.]</i></p> <ul style="list-style-type: none"> <li>• Blood, including storage and administration</li> <li>• Physician services</li> </ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are you a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> |                   |
| <p><b>Inpatient services in a psychiatric hospital</b></p> <p>We pay for mental health care services that require a hospital stay. <i>[List days covered, restrictions such as 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.]</i></p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay |
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| <p><i>[Plans with no day limitations on a plan's hospital or nursing facility coverage may modify or delete this row as appropriate.]</i></p> <p><b>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</b></p> <p>We do not pay for your inpatient stay if it is not reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Doctor services</li> <li>• Diagnostic tests, like lab tests</li> <li>• X-ray, radium, and isotope therapy, including technician materials and services</li> <li>• Surgical dressings</li> <li>• Splints, casts, and other devices used for fractures and dislocations</li> <li>• Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: <ul style="list-style-type: none"> <li>○ An internal body organ (including contiguous tissue), <b>or</b></li> <li>○ The function of an inoperative or malfunctioning internal body organ.</li> </ul> </li> <li>• Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition</li> <li>• Physical therapy, speech therapy, and occupational therapy</li> </ul> | <p>\$0</p>        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay |
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| <p><b>Kidney disease services and supplies</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services.</li><li>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in <b>Chapter 3</b> of your <i>Member Handbook</i>, or when your provider for this service is temporarily unavailable or inaccessible.</li><li>• Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care</li><li>• Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments</li><li>• Home dialysis equipment and supplies</li><li>• Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply.</li></ul> <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.</p> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay                                               |
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|  <p><b>Lung cancer screening</b></p> <p>Our plan pays for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> <li>• Are aged 50-77, <b>and</b></li> <li>• Have a counseling and shared decision-making visit with your doctor or other qualified provider, <b>and</b></li> <li>• Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.</li> </ul> <p>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.</p> <p><i>[Modify section to accurately describe benefits and list any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                           | <p>\$0</p>                                                      |
|  <p><b>Medical nutrition therapy</b></p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when <i>[insert as appropriate: referred or ordered]</i> by your doctor.</p> <p>We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.</p> <p>We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's <i>[insert as appropriate: referral or order]</i>. A doctor must prescribe these services and renew the <i>[insert as appropriate: referral or order]</i> each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | What you must pay |
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|  <b>Medicare Diabetes Prevention Program (MDPP)</b><br>Our plans pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: <ul style="list-style-type: none"> <li>• Long-term dietary change, <b>and</b></li> <li>• Increased physical activity, <b>and</b></li> <li>• Ways to maintain weight loss and a healthy lifestyle.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$0               |
| <b>Medicare Part B prescription drugs</b><br><i>[Plans that do or expect to use Medicare Part B step therapy should indicate the Medicare Part B drug categories below that are or may be subject to Medicare Part B step therapy as well as a link to a list of drugs subject to Medicare Part B step therapy. Plans may update the link throughout the year and add any changes at least 30 days prior to implementation per 42 CFR 422.111(d).]</i><br>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: <ul style="list-style-type: none"> <li>• Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <li>• Osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay |
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| <p><b>Medicare Part B prescription drugs (continued)</b></p> <ul style="list-style-type: none"> <li>Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents <i>[plans may delete any of the following drugs that they do not not cover]</i> (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</li> <li>IV immune globulin for the home treatment of primary immune deficiency diseases</li> </ul> <p><i>[Insert if applicable: The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: &lt;hyperlink&gt;.]</i></p> <p>We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit.</p> <p><b>Chapter 5</b> of your <i>Member Handbook</i> explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p><b>Chapter 6</b> of your <i>Member Handbook</i> explains what you pay for your outpatient prescription drugs through our plan.</p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay            |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate or eliminate this section if not covered.]</i></p> <p><b>Nursing facility care</b></p> <p>A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital.</p> <p>Services that we pay for include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Nursing services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Respiratory therapy</li> <li>• Drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)</li> <li>• Blood, including storage and administration</li> <li>• Medical and surgical supplies usually given by nursing facilities</li> <li>• Lab tests usually given by nursing facilities</li> <li>• X-rays and other radiology services usually given by nursing facilities</li> <li>• Use of appliances, such as wheelchairs usually given by nursing facilities</li> <li>• Physician/practitioner services</li> <li>• Durable medical equipment</li> <li>• Dental services, including dentures</li> <li>• Vision benefits</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                               |
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| <p><b>Nursing facility care (continued)</b></p> <ul style="list-style-type: none"> <li>• Hearing exams</li> <li>• Chiropractic care</li> <li>• Podiatry services</li> </ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> <li>• A nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care).</li> <li>• A nursing facility where your spouse or domestic partner is living at the time you leave the hospital.</li> </ul> |                                                                 |
| <p> <b>Obesity screening and therapy to keep weight down</b></p> <p>If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                         | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
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| <p><b>Opioid treatment program (OTP) services</b></p> <p>Our plan pays for the following services to treat opioid use disorder (OUD):</p> <ul style="list-style-type: none"> <li>• Intake activities</li> <li>• Periodic assessments</li> <li>• Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications</li> <li>• Substance use counseling</li> <li>• Individual and group therapy</li> <li>• Testing for drugs or chemicals in your body (toxicology testing)</li> </ul> <p><i>[List any other medically necessary treatment or additional benefits offered, with the exception of meals and transportation.]</i></p> | \$0               |
| <p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy, including technician materials and supplies</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts, and other devices used for fractures and dislocations</li> <li>• Lab tests</li> <li>• Blood, including storage and administration</li> <li>• Other outpatient diagnostic tests</li> </ul> <p><i>[Plans can include other covered tests as appropriate.]</i></p>                   | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay                                               |
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| <p><b>Outpatient hospital services</b></p> <p>We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"><li>• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services<ul style="list-style-type: none"><li>○ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.”</li><li>○ Sometimes you can be in the hospital overnight and still be “outpatient.”</li><li>○ You can get more information about being inpatient or outpatient in this fact sheet: <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a></li></ul></li><li>• Labs and diagnostic tests billed by the hospital</li><li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it</li><li>• X-rays and other radiology services billed by the hospital</li><li>• Medical supplies, such as splints and casts</li><li>• Preventive screenings and services listed throughout the Benefits Chart</li><li>• Some drugs that you can’t give yourself</li></ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



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| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay                                               |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient mental health care</b></p> <p>We pay for mental health services provided by:</p> <ul style="list-style-type: none"><li>• A state-licensed psychiatrist or doctor</li><li>• A clinical psychologist</li><li>• A clinical social worker</li><li>• A clinical nurse specialist</li><li>• A nurse practitioner</li><li>• A physician assistant</li><li>• Any other Medicare-qualified mental health care professional as allowed under applicable state laws</li></ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient rehabilitation services</b></p> <p>We pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p>                                                                                                                                                                                               | <p>\$0</p>                                                      |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay            |
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| <p><b>Outpatient substance abuse services</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Alcohol misuse screening and counseling</li> <li>• Treatment of drug abuse</li> <li>• Group or individual counseling by a qualified clinician</li> <li>• Subacute detoxification in a residential addiction program</li> <li>• Alcohol and/or drug services in an intensive outpatient treatment center</li> <li>• Extended-release Naltrexone (vivitrol) treatment</li> </ul> <p><i>[Modify this list accurately describe benefits offered or add any additional benefits offered.]</i></p>                                                                                        | <p><i>[List copays.]</i></p> |
| <p><b>Outpatient surgery</b></p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p>                   |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Partial hospitalization services</b></p> <p>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.</p> <p><i>[Network plans that do not have an in-network community mental health center may add: <b>Note:</b> Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.]</i></p> | <p>\$0</p>                   |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | What you must pay                                               |
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| <p><b>Physician/provider services, including doctor's office visits</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Medically necessary health care or surgery services given in places such as:</li><li>• Physician's office</li><li>• Certified ambulatory surgical center</li><li>• Hospital outpatient department</li><li>• Consultation, diagnosis, and treatment by a specialist</li><li>• Basic hearing and balance exams given by your <i>[insert as applicable: primary care provider or specialist]</i>, if your doctor orders them to find out whether you need treatment</li><li>• <i>[Insert if providing any additional telehealth benefits consistent with 42 CFR § 422.135 in the plan's approved Plan Benefit Package submission: Certain telehealth services, including [insert general description of covered additional telehealth benefits (i.e., the specific Medicare Part B service(s) the plan has identified as clinically appropriate for offering through electronic exchange when the provider is not in the same location as the member). Plans may refer members to their medical coverage policy here].]</i></li></ul> <p><b>This benefit is continued on the next page</b></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"><li>○ 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. <i>[Plans may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.]</i></li><li>○ <i>[List the available means of electronic exchange used for each Medicare Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.]</i></li><li>● <i>[Insert if the plan's service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act: Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare]</i></li><li>● Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home</li><li>● Telehealth services to diagnose, evaluate, or treat symptoms of a stroke</li><li>● Telehealth services for members with a substance use disorder or co-occurring mental health disorder</li></ul> <p><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | What you must pay |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"><li>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:<ul style="list-style-type: none"><li>○ You have an in-person visit within 6 months prior to your first telehealth visit</li><li>○ You have an in-person visit every 12 months while receiving these telehealth services</li><li>○ Exceptions can be made to the above for certain circumstances</li></ul></li><li>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.</li><li>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b><ul style="list-style-type: none"><li>○ you're not a new patient <b>and</b></li><li>○ The check-in isn't related to an office visit in the past 7 days and</li><li>○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment</li></ul></li><li>• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours <b>if</b>:<ul style="list-style-type: none"><li>○ you're not a new patient and</li><li>○ The evaluation isn't related to an office visit in the past 7 days <b>and</b></li><li>○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment</li></ul></li></ul> <p><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay                                               |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient</li> <li>• Second opinion <i>[insert if appropriate: by another network provider]</i> before surgery</li> <li>• Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> <li>○ Surgery of the jaw or related structures</li> <li>○ Setting fractures of the jaw or facial bones</li> <li>○ Pulling teeth before radiation treatments of neoplastic cancer</li> <li>○ Services that would be covered when provided by a physician</li> </ul> </li> </ul> <p><i>[List any additional benefits offered.]</i></p> |                                                                 |
| <p><b>Podiatry services</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)</li> <li>• Routine foot care for members with conditions affecting the legs, such as diabetes</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p> <b>Prostate cancer screening exams</b></p> <p><i>[Plans that cover men under age 65 must include: For men age 50 and older,]</i> we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> <li>• A digital rectal exam</li> <li>• A prostate specific antigen (PSA) test</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                               |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Prosthetic devices and related supplies</b></p> <p>Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> <li>• Colostomy bags and supplies related to colostomy care</li> <li>• Pacemakers</li> <li>• Braces</li> <li>• Prosthetic shoes</li> <li>• Artificial arms and legs</li> <li>• Breast prostheses (including a surgical brassiere after a mastectomy)</li> </ul> <p>We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.</p> <p><i>[Plans that pay for prosthetic dental devices, delete the following sentence:]</i> We will not pay for prosthetic dental devices.</p> | <p>\$0</p>                                                      |
| <p><b>Pulmonary rehabilitation services</b></p> <p>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have <i>[insert as appropriate: a referral or an order]</i> for pulmonary rehabilitation from the doctor or provider treating the COPD.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



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| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                 |
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|  <b>Sexually transmitted infections (STIs) screening and counseling</b><br><br>We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered <a href="#">[plans that cover women under age 65 should include: for pregnant women and]</a> for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.<br><br>We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.<br><br><a href="#">[Also list any additional benefits offered.]</a> | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | What you must pay |
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| <p><b>Skilled nursing facility (SNF) care</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"><li>• A semi-private room, or a private room if it is medically necessary</li><li>• Meals, including special diets</li><li>• Nursing services</li><li>• Physical therapy, occupational therapy, and speech therapy</li><li>• Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors</li><li>• Blood, including storage and administration</li><li>• Medical and surgical supplies given by nursing facilities</li><li>• Lab tests given by nursing facilities</li><li>• X-rays and other radiology services given by nursing facilities</li><li>• Appliances, such as wheelchairs, usually given by nursing facilities</li><li>• Physician/provider services</li></ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"><li>• A nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)</li><li>• A nursing facility where your spouse or domestic partner lives at the time you leave the hospital</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay                                                 |
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| <div data-bbox="155 468 191 506"></div> <p><b>Smoking and tobacco use cessation</b></p> <p>If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit:</p> <ul style="list-style-type: none"> <li>• We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.</li> </ul> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</p> <ul style="list-style-type: none"> <li>• We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for supplemental benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay |
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| <p><b>Supervised exercise therapy (SET)</b></p> <p>We pay for SET for members with symptomatic peripheral artery disease (PAD) <i>[insert if applicable: who have a referral for PAD from the physician responsible for PAD treatment]</i>.</p> <p>Our plan pays for:</p> <ul style="list-style-type: none"><li>• Up to 36 sessions during a 12-week period if all SET requirements are met</li><li>• An additional 36 sessions over time if deemed medically necessary by a health care provider</li></ul> <p>The SET program must be:</p> <ul style="list-style-type: none"><li>• 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)</li><li>• In a hospital outpatient setting or in a physician's office</li><li>• Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD</li><li>• Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay |
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| <p><b>Urgently needed care</b></p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"><li>• A non-emergency that requires immediate medical care, <b>or</b></li><li>• A sudden medical illness, <b>or</b></li><li>• An injury, <b>or</b></li><li>• A condition that needs care right away.</li></ul> <p>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or during the weekend).</p> <p><i>[Include in-network benefits. Also identify whether this coverage is within the U.S. and its territories or is supplemental world-wide emergency/urgent coverage.]</i></p> | <p>\$0</p>        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
|  <i>[Plans should modify this section to reflect Medicaid and plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]</i><br><b>Vision care</b><br><br>We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.<br><br>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: <ul style="list-style-type: none"><li>• People with a family history of glaucoma</li><li>• People with diabetes</li><li>• African-Americans <i>[plans that cover under 65 must include: who are age 50 and older]</i></li><li>• Hispanic Americans <i>[plans that cover under 65 must include: who are 65 or older]</i></li></ul> <i>[Plans should modify this description if the plan offers more than is covered by Medicare.]</i> We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.<br><br>If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery. | <i>[List copays.]</i><br><br><i>[List copays for additional benefits.]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
|  <p><b>“Welcome to Medicare” preventive visit</b></p> <p>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> <li>• A review of your health,</li> <li>• Education and counseling about the preventive services you need (including screenings and shots), <b>and</b></li> <li>• Referrals for other care if you need it.</li> </ul> <p><b>Note:</b> We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.</p> | \$0               |

## E. Extra “Optional Supplemental” benefits you can buy

*[Include this section if you offer optional supplemental benefits in the plan and describe benefits below. Plans must explain how these benefits are different than what is covered under Medicaid and must indicate if any of the optional supplemental benefits are covered by Medicaid. You may include this section either in the Member Handbook or as an insert to the Member Handbook.]*

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package. These extra benefits are called “**Optional Supplemental Benefits**.” If you want these optional supplemental benefits, you must sign up for them *[insert if applicable: and you may have to pay an additional premium for them.]* The optional supplemental benefits described in *[insert as applicable: this section OR the enclosed insert]* are subject to the same appeals process as any other benefits.

*[Insert plan specific optional supplemental benefits, premiums, deductible, copays, and coinsurance and rules using a chart like the Benefits Chart above. Insert plan specific procedures on how to elect optional supplemental coverage, including application process and effective dates and on how to discontinue optional supplemental coverage, including refund of premiums. Also, insert any restrictions on members’ re-applying for optional supplemental coverage (e.g., must wait until next annual enrollment period).]*

**Commented [JJ3]:** Janelle Sharp-Supplemental Dental, vision, hearing - chart instructs plan to place supplemental benefit in section E. But the title for section E is “Supplemental benefits you can buy” and instructions do not say we can revise the title when supplement benefit have no extra premium. Should plans be adding free supp benefits to the medical chart, or section E?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## F. Our plan's visitor or traveler benefits

*[If your plan offers a visitor/traveler program to members who are out of your service area, insert this section, adapting and expanding the following paragraphs as needed to describe the traveler benefits and rules related to getting the out-of-area coverage. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR §422.74(b)(4)(iii) (for more than 6 months up to 12 months), also explain that here based on the language suggested below:]*

If you are out of the plan's service area for more than 6 months at a time but do not permanently move, we usually must disenroll you from our plan. However, we offer a visitor/traveler program *[specify areas where the visitor/traveler program is being offered]* that allows you to remain enrolled in our plan when you are outside of our service area for up to 12 months. Under our visitor/traveler program, you get all plan-covered services at in-network cost-sharing prices. Contact us for help in finding a provider when you use the visitor/traveler benefit.

If you are in a visitor/traveler area, you can stay enrolled in the plan until <end date>. If you don't return to our plan's service area by <end date>, we will end your membership in our plan.]

## G. Benefits covered outside of our plan

*[Plans should modify this section to include additional benefits covered outside the plan by Medicaid fee-for-service and/or a Medicaid managed care plan, as appropriate.]*

We don't cover the following services, but they are available through Medicare or *[insert name state-specific name of Medicaid program]*.

### G1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

#### **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis**

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

#### **For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

#### For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook*.

**Note:** If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care not related to your terminal prognosis.

---

## H. Benefits not covered by our plan, Medicare, or *[insert name of state-specific Medicaid program]*.

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medicaid do not for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan does not cover the following items and services:

*[The services listed in the remaining bullets are excluded from Medicare's and Medicaid's benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Medicaid or have become covered due to a Medicare or Medicaid change in coverage policy, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans may add parenthetical references to the Benefits Chart for descriptions of covered services and items as appropriate. Plans may also add exclusions as needed.]*

- Services considered not "reasonable and medically necessary," according to Medicare and *[insert name state-specific name of Medicaid program]* standards, unless we list these as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Refer to **Chapter 3** of your *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it.
- A private room in a hospital, except when medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- *[Plans should delete this if the state allows:]* Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines.
- Routine foot care, except as described in Podiatry services in the Benefits Chart in Section D.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- *[Plans delete this if supplemental:]* Regular hearing exams, hearing aids, or exams to fit hearing aids.
- *[Plans delete this if supplemental:]* Radial keratotomy, LASIK surgery, and other low-vision aids.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. [\[Zero cost-sharing plans may adjust this language as applicable\]](#) However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Instructions to Health Plans

- ❖ *[Plans may include the ANOC in the 2024 Member Handbook (Evidence of Coverage) or provide it to members separately.]*
- ❖ *[Plans may modify the language in the ANOC, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]*
- ❖ *[Plans must use the state-specific name for Medicaid in references to “Medicaid” in any plan-customized language throughout the ANOC.]*
- ❖ *[Throughout the document update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medicaid plans, etc.).]*
- ❖ *[Where the ANOC uses “medical care,” “medical services,” or “health care services” to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]*
- ❖ *[Plans may change references to terms such as “member,” “customer,” “beneficiary,” “enrollee,” “member services,” “care coordinator,” “primary care provider,” “prior authorization (PA)” as instructed by the state or based on plan preference and update them consistently throughout the ANOC.]*
- ❖ *[Where the model material instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]*
- ❖ *[Throughout the ANOC, plans must follow the applicable style rules of the state, if any. For instance, where the model material instructs inclusion of a date or time, plans must use the specific format requested by the state Medicaid program. Other items covered by a state-specific style guide or similar document should also be updated accordingly.]*
- ❖ *[Plans should refer to the Member Handbook as needed using the appropriate chapter number, section, and/or page number. For example, “refer to Chapter 9, Section A, page 1.” An instruction [insert reference, as applicable] appears with many cross references throughout the ANOC and Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*
- ❖ *[Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).*
- *Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.*
- *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
- *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.*
- *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
- *Avoid separating a heading or subheading from the text that follows when paginating the model.*
- *Use universal symbols or commonly understood pictorials.*
- *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
- *Consider using regionally appropriate terms or common dialects in translated models.*
- *Include instructions and navigational aids in translated models in the translated language rather than in English.*
- *Consider producing translated models in large print.]*



<Plan name> [insert plan type] offered by [insert sponsor name]

# Annual Notice of Changes for 2024

[Optional: insert member name]

[Optional: insert member address]

## Introduction

[If there are any changes to the plan for 2024, insert: You are currently enrolled as a member of our plan. Next year, there will be some changes to our [insert as applicable: benefits, coverage, rules, [and] costs]. This [insert as applicable: section or Annual Notice of Changes] tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at [insert URL]. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.]

[If there are no changes whatsoever for 2024 (e.g., no changes to benefits, coverage, rules, costs, networks), insert: You are currently enrolled as a member of our plan. Next year, there are no changes to our benefits, coverage, [and] rules [insert if applicable: and costs]. However, you should still read this [insert as applicable: section or Annual Notice of Changes] to learn about your coverage choices. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at [insert URL]. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.]

[Any plan that does not include a particular section (e.g., Section C, Section F) deletes the section, orders all remaining sections and subsections sequentially, and updates the Table of Contents accordingly. Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Disclaimers

- ❖ *[Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidance and included in any state-specific guidance provided by <insert state>.] [Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, here.]*

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## B. Reviewing your Medicare and *[Insert name of Medicaid program]* coverage for next year

It is important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section E** for more information.

If you choose to leave our plan, your membership will end on the last day of the month in which your request was made. You will still be in the Medicare and *[Insert name of Medicaid program]* programs as long as you are eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section G2** *[insert reference, as applicable]*.
- *[Insert name of Medicaid program]* services in **Section G2** *[insert reference, as applicable]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B1. Additional resources

- ATTENTION: If you speak *[insert language of the disclaimer]*, language assistance services, free of charge, are available to you. Call *[insert Member Services toll-free phone and TTY numbers, and days and hours of operation]*. The call is free. *[This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation.]*
- You can get this *[Insert as applicable: section or Annual Notice of Changes]* for free in other formats, such as large print, braille, or audio. Call *[insert Member Services toll-free phone and TTY numbers, and days and hours of operation]*. The call is free.
- *[Plans also simply describe:*
  - *how they request a member's preferred language other than English and/or alternate format,*
  - *how they keep the member's information as a standing request for future mailings and communications so the member does not need to make a separate request each time, and*
  - *how a member can change a standing request for preferred language and/or format.]*

## B2. Information about *<plan name>*

- *[Insert plan's legal or marketing name]* is a health plan that contracts with both Medicare and Medicaid to provide benefits of both programs to members.
- Coverage under *[insert plan name]* is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.
- When this *Annual Notice of Changes* says "we," "us," "our," or "our plan," it means *[insert plan name]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### B3. Important things to do

- **Check if there are any changes to our benefits** *[insert if applicable: and costs]* **that may affect you.**
  - Are there any changes that affect the services you use?
  - Review benefit *[insert if applicable: and cost]* changes to make sure they will work for you next year.
  - Refer to **Section E1** for information about benefit *[insert if applicable: and cost]* changes for our plan.
- **Check if there are any changes to our prescription drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different *[insert if applicable: cost-sharing]* tier? Can you use the same pharmacies?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section E2** for information about changes to our drug coverage.
  - *[All plans with any Medicare Part D cost sharing insert: Your drug costs may have risen since last year.*
    - Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year.
    - Keep in mind that your plan benefits determine exactly how much your own drug costs may change.]
- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section D** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
  - *[Insert if applicable: How much will you spend out-of-pocket for the services and prescription drugs you use regularly?]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- How do the total costs compare to other coverage options?
- **Think about whether you are happy with our plan.**

**If you decide to stay with <2024 plan name>:**

If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in <2024 plan name>.

**If you decide to change plans:**

*[Plans should revise this paragraph as necessary]* If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section G2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

---

**C. Changes to our plan name**

*[Plans that are not changing the plan name, delete this section. Plans with an anticipated name change at a time other than January 1 may modify the date below as necessary.]*

On January 1, 2024, our plan name changes from <2023 plan name> to <2024 plan name>.

*[Insert language to inform members whether they will get new plan ID cards and how, as well as how the name change affects any other member communication.]*

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**D. Changes to our network providers and pharmacies**

*[Plans with no changes to network providers and pharmacies insert: We have not made any changes to our network of providers and pharmacies for next year.]*

However, it's important that you know that we may make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook*.

*[Plans with changes to provider and/or pharmacy networks, insert: Our [insert if applicable: provider] [and] [insert if applicable: pharmacy] network[s] [insert as applicable: has or have] changed for 2024.]*

Please **review the 2024 Provider and Pharmacy Directory** to find out if your providers or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

website at <web address>. You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook*.]

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**E. Changes to benefits [insert if applicable: and costs] for next year**

**E1. Changes to benefits [insert if applicable: and costs] for medical services**

[If there are no changes in benefits or in cost sharing, replace the rest of the section with: There are no changes to your benefits [insert if applicable: or amounts you pay] for medical services. Our benefits [insert if applicable: and what you pay for these covered medical services] will be exactly the same in 2024 as they are in 2023.]

We're changing our coverage for certain medical services [insert if applicable: and what you pay for these covered medical services] next year. The table below describes these changes.

[The table must include:

- All new benefits that will be added or 2023 benefits that will end for 2024;
- New or changing limitations or restrictions, including prior authorizations (PA), on benefits for 2024; **and**
- All changes in cost sharing for 2024 for covered medical services, including any changes to service category out-of-pocket maximums.]



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                              | 2023 (this year)                                                                                                                                                                                                                                                                                               | 2024 (next year)                                                                                                                                                                                                                                                                                                  |
|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>[Insert benefit name]</i> | <i>[For benefits that were not covered in 2023, insert:<br/><br/>[insert benefit name] is <b>not</b> covered.]<br/><br/>[For benefits with a copay insert:<br/><br/>You pay a \$&lt;2023 copay amount&gt; copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].]</i> | <i>[For benefits that will not be covered in 2024, insert:<br/><br/>[insert benefit name] is <b>not</b> covered.]<br/><br/>[For benefits with a copay insert:<br/><br/>You pay a \$&lt;2024 copay amount&gt; copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].]</i> |
| <i>[Insert benefit name]</i> | <i>[Insert 2023 cost or coverage, using format described above.]</i>                                                                                                                                                                                                                                           | <i>[Insert 2024 cost or coverage, using format described above.]</i>                                                                                                                                                                                                                                              |

**E2. Changes to prescription drug coverage**

**Changes to our Drug List**

*[Plans that did not include a List of Covered Drugs in the envelope, insert: You will get a 2024 List of Covered Drugs in a separate mailing.]*

*[Plans that did not include a List of Covered Drugs in the envelope and will not mail it separately unless requested, insert: An updated List of Covered Drugs is located on our website at <web address>. You may also call Member Services at the numbers at the bottom of the page for updated drug information or to ask us to mail you a List of Covered Drugs.]*

*[Plans that included a List of Covered Drugs in the envelope, insert: We sent you a copy of our 2024 List of Covered Drugs in this envelope.] The List of Covered Drugs is also called the “Drug List.”*

*[Plans with no changes to covered drugs, tier assignment, or restrictions may replace the rest of this section with: We have not made any changes to our Drug List for next year. However, we are allowed to make changes to the Drug List from time to time throughout the year, with approval from Medicare and/or the state. Refer to the 2024 Drug List for more information.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs.

Review the Drug List to **make sure your drugs will be covered next year** and to find out if there are any restrictions.

If you are affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
  - You can call Member Services at the numbers at the bottom of the page [\[insert if applicable: or contact your care coordinator\]](#) to ask for a list of covered drugs that treat the same condition.
  - This list can help your provider find a covered drug that might work for you.
- [\[Plans should include the following language if they have an advance transition process for current members:\]](#) Work with your doctor (or other prescriber) and ask us to make an exception to cover the drug.
  - You can ask for an exception before next year, and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement).
  - To learn what you must do to ask for an exception, refer to **Chapter 9** of your *Member Handbook* or call Member Services at the numbers at the bottom of the page.
  - If you need help asking for an exception, contact Member Services [\[insert if applicable: or your care coordinator\]](#). Refer to **Chapters 2 and 3** of your *Member Handbook* to learn more about how to contact your care coordinator.
- [\[Plans should include the following language if all current members will not be transitioned in advance for the following year:\]](#) Ask us to cover a temporary supply of the drug.
  - In some situations, we cover a **temporary** supply of the drug during the first [\[must be at least 90\]](#) days of the calendar year.
  - This temporary supply is for up to [\[insert supply limit \(must be the number of days in plan's one-month supply\)\]](#) days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
  - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



different drug our plan covers or ask us to make an exception for you and cover your current drug.

*[Plans may include additional information about processes for transitioning current enrollees to formulary drugs when your formulary changes relative to the previous plan year.]*

*[Include language to explain whether current formulary exceptions will still be covered next year or a new one needs to be submitted.]*

**Changes to prescription drug costs** *[option for plans with two drug payment stages]*

*[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), should include the following information in the ANOC.]*

*[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]*

There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

| Stage 1<br>Initial Coverage Stage                                                                                                                                                                        | Stage 2<br>Catastrophic Coverage Stage                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay.<br><br>You begin this stage when you fill your first prescription of the year. | During this stage, the plan pays all of the costs of your drugs through December 31, 2024.<br><br>You begin this stage after you pay a certain amount of out-of-pocket costs. |

**Commented [LW1]:** Template only allows for single and two payment stage charts. Will there be an option to include a four stage chart like the standard Part D model? If not, where would we report changes to coverage gap?

**Commented [LW2]:** For plans that file \$0 RX on all tiers through VBID, would this be considered single stage?

The Initial Coverage Stage ends when your total out-of-pocket costs for prescription drugs reaches *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you will pay for prescription drugs.

**E3. Stage 1: “Initial Coverage Stage”**

During the Initial Coverage Stage, our plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Insert if applicable: We moved some of the drugs on our Drug List to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our Drug List.]*

The following table shows your costs for drugs in each of our *[insert number of tiers]* drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

*[Plans must list all drug tiers in the following table.]*

|                                                                                                                                                                                                                           | 2023 (this year)                                                                                                                                           | 2024 (next year)                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |

The Initial Coverage Stage ends when your total out-of-pocket costs reach *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point the Catastrophic Coverage Stage begins. The plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information how much you pay for prescription drugs.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**E4. Stage 2: “Catastrophic Coverage Stage”**

When you reach the out-of-pocket limit *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]* for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year.

- *[Plans that do not reduce the copays for [insert name of the Medicaid program]-covered drugs in the catastrophic coverage stage should insert the following language: To locate more information about your prescriptions that Medicare and [insert name of the Medicaid program] cover, refer to the List of Covered Drugs, [insert reference, as applicable].]*

**Changes to prescription drug costs** *[option for plans with a single payment stage]*

*[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following information.]*

*[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]*

*[Insert if applicable: We moved some of the drugs on the Drug List to a lower or higher drug tier. [Insert if applicable: If your drugs move from tier to tier, this could affect your copay.] To find out if your drugs are in a different tier, look them up in the Drug List.]*

The following table shows your costs for drugs in each of our *[insert number of tiers]* drug tiers.

*[Plans must list all drug tiers in the following table.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                           | 2023 (this year)                                                                                                                                           | 2024 (next year)                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |

**F. Administrative changes**

*[Insert this section if applicable. Plans with administrative changes that impact members (e.g., change in contract or PBP number) may insert this section, include an introductory sentence that explains the general nature of administrative changes, and describe the specific changes in the table below. Plans that choose to omit this section should renumber the remaining sections as needed.]*

|                                                                                   | 2023 (this year)                                | 2024 (next year)                                |
|-----------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <i>[Insert a description of the administrative process/item that is changing]</i> | <i>[Insert 2023 administrative description]</i> | <i>[Insert 2024 administrative description]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                   | 2023 (this year)                                | 2024 (next year)                                |
|-----------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <i>[Insert a description of the administrative process/item that is changing]</i> | <i>[Insert 2023 administrative description]</i> | <i>[Insert 2024 administrative description]</i> |

## G. Choosing a plan

### G1. Staying in our plan

We hope to keep you as a plan member. You do not have to do anything to stay in our plan. If you do **not** change to another Medicare plan or change to Original Medicare, you automatically stay enrolled as a member of our plan for 2024.

### G2. Changing plans

*[Plans should add any additional Medicaid information as directed by the state.]* Most people with Medicare can end their membership during certain times of the year. Because you have *[Insert name of Medicaid program]*, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You moved out of our service area,
- Your eligibility for *[Insert name of Medicaid Program]* or Extra Help changed, **or**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

**Your Medicare services**

You have three options for getting your Medicare services. By choosing one of these options, you automatically end your membership in our plan. *[Insert additional option to change to another integrated program as directed by the state.]*

|                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>1. You can change to:</b></p> <p><b>Another Medicare health plan</b> <i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>For PACE inquiries, call 1-855-921-PACE (7223).</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call the <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i> For more information or to find a local <i>[insert name of SHIP office]</i> office in your area, please visit <i>[insert website address]</i>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare plan.</p> <p>You will automatically be disenrolled from our plan when your new plan’s coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>2. You can change to:</b></p> <p><b>Original Medicare with a separate Medicare prescription drug plan</b></p> <p><i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i> For more information or to find a local <i>[insert name of office]</i> office in your area, please visit <i>[insert website address]</i>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare prescription drug plan.</p> <p>You will automatically be disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>3. You can change to:</b></p> <p><b>Original Medicare without a separate Medicare prescription drug plan</b></p> <p><i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> <p><b>NOTE:</b> If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join.</p> <p>You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i></li></ul> <p>You will automatically be disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Your *[insert name of state Medicaid program]* services**

For questions about how to get your *[insert name of Medicaid program]* services after you leave our plan, contact *[insert name of program, phone number, days and hours of operation, and TTY number and website if applicable]*. Ask how joining another plan or returning to Original Medicare affects how you get your *[insert name of Medicaid program]* coverage.

**H. Getting help**

**H1. Our plan**

We're here to help if you have any questions. Call Member Services at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

**Read your *Member Handbook***



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits *[insert if applicable: and costs]* for 2024. It explains your rights and the rules to follow to get services and prescription drugs we cover.

*[If the ANOC is sent or provided separately from the Member Handbook, include the following: The Member Handbook for 2024 will be available by October 15.] [Insert if applicable: You can also review the <attached or enclosed or separately mailed> Member Handbook to find out if other benefit [insert if applicable: or cost] changes affect you.]* An up-to-date copy of the *Member Handbook* is available on our website at *<web address>*. You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2024.

#### **Our website**

You can visit our website at *<web address>*. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our Drug List (*List of Covered Drugs*).

#### **H2. *[Insert name of the State Health Insurance Assistance Program (SHIP)]***

You can also call the State Health Insurance Assistance Program (SHIP). In *[Insert name of state]* the SHIP is called the *[Insert name of program]*. *[Insert name of program staff]* can help you understand your plan choices and answer questions about switching plans. *[Insert name of program]* HICAP is not connected with us or with any insurance company or health plan. *[Insert name of program]* has trained counselors *[insert in every county or locations]* and services are free. *[Insert name of program]* phone number is *[TTY phone number is optional.]* For more information or to find a local *[Insert name of program]* office in your area, please visit *[insert website address]*.

#### **H3. *[Insert State-specific name for ombudsman program]***

*[Insert this section if there is an ombudsman program in the state. Include a description of what the program can do, whether the services are free, and phone number. Please refer to an example of language below.]*

*[Optional language example: The Ombudsman Program can help you if you have a problem with our plan. The ombudsman's services are free and available in all languages. The Ombudsman Program:*

- Works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do.*
- Makes sure you have information related to your rights and protections and how you can get your concerns resolved.*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Is not connected with us or with any insurance company or health plan. The phone number for the Ombudsman Program is [insert phone number].*

#### **H4. Medicare**

To get information directly from Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

##### **Medicare's Website**

You can visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to [www.medicare.gov](http://www.medicare.gov) and click on "Find plans.")

##### **Medicare & You 2024**

You can read the *Medicare & You 2024* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf](http://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf)) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

*[Insert any additional sections as required by the state, such as the QIO or additional resources that might be available.]*

#### **H5. [Insert state-specific name of Medicaid program.]**

*[Insert a description of the state Medicaid program's role and how to receive assistance from the state.]*

#### **H6. [Insert additional resources if applicable]**

*[If applicable, insert a new section for each additional resource, including contact information and a description of their role.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## <Plan name> *Member Handbook*

- ❖ *[Plans may add a front cover to the Member Handbook that contains information such as the plan name, Member Handbook title, and contact information for Member Services. Plans may add a logo and/or photographs to the front cover as long as these elements do not make it difficult for members to read other information on the cover. If plans add a front cover, it must contain the Material ID.]*
- ❖ *[Plans must use the state-specific name for Medicaid in references to “Medicaid” in any plan-customized language throughout the Member Handbook.]*
- ❖ *[Plans may modify the language in the Member Handbook, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]*
- ❖ *[Throughout the document plans should update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medicaid plans, etc.)]*
- ❖ *[Where the Member Handbook uses “medical care,” “medical services,” or “health care services” to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]*
- ❖ *[Plans may change references to terms such as “member,” “customer,” “beneficiary,” “member services,” “health risk assessment,” “care coordinator,” “primary care provider,” “prior authorization (PA),” “nursing facility”, and “urgently needed care”, etc. as instructed by the state or based on plan preference and update them consistently throughout the Member Handbook.]*
- ❖ *[Where the model material instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]*
- ❖ *[Throughout the Member Handbook, in addition to following all Medicare and Medicaid requirements in regulation and the Medicare Communications and Marketing Guidelines, plans must follow additional applicable style rules of the state, if any.]*
- ❖ *[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number as appropriate. For example, “refer to Chapter 9, Section A, page 1.” An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*
- ❖ *[Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:]*

**Commented [LW1]:** Suggest aligning template more closely to the CMS D-SNP EOC template in structure. Specifically, aligning the TOC section, chapter numbering, and names of the sections and chapters would help tremendously. Aligning the content to the greatest extent possible would be helpful as well.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).*
- *Ensure plan-customized text is in plain language and complies with reading level requirements established in by the state.*
- *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
- *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.*
- *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
- *Avoid separating a heading or subheading from the text that follows when paginating the model.*
- *Use universal symbols or commonly understood pictorials.*
- *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
- *Consider using regionally appropriate terms or common dialects in translated models.*
- *Include instructions and navigational aids in translated models in the translated language rather than in English.*
- *Consider producing translated models in large print.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

<start date> – <end date>

## Your Health and Drug Coverage under <plan name>

*[Plans: Revise this language to reflect that the organization is providing both Medicaid and Medicare covered benefits, when applicable.]*

*[Optional: Insert member name.]*

*[Optional: Insert member address.]*

### **Member Handbook Introduction**

This *Member Handbook*, otherwise known as the *Evidence of Coverage*, tells you about your coverage under our plan through <end date>. It explains health care services *[plans may add references to other behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports, as needed]*. Key terms and their definitions appear in alphabetical order in Chapter 12 of your *Member Handbook*.

**This is an important legal document. Keep it in a safe place.**

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means *[insert plan name]*.

ATTENTION: If you speak *[insert language of the disclaimer]*, free language assistance services are available to you. Call <plan name> Member Services at the number at the bottom of this page. The call is free. *[This disclaimer must be included in all non-English languages that meet the Medicare or state thresholds for translation.]*

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

*[Plans also simply describe:*

- *how they request a member's preferred language other than English and/or alternate format,*
- *how they keep the member's information as a standing request for future mailings and communications so the member does not need to make a separate request each time, **and***
- *how a member can change a standing request for preferred language and/or format.]*

*[Plans must include an overall Table of Contents for the Member Handbook after the Member Handbook Introduction and before the Member Handbook Disclaimers.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Disclaimers

- ❖ *[Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidelines, and included in any state-specific guidance.]*
- ❖ *[Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, [here](#).]*
- ❖ Coverage under *[insert plan name]* is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 1: Getting started as a member

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### Introduction

This chapter includes information about *[insert plan name]*, a health plan that *[insert description of the relationship such as covers or coordinates]* all of your Medicare and *[insert name of Medicaid program]* services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

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---

## A. Welcome to our plan

*[Insert language to describe the relationship between the Medicare and Medicaid services. For example: Our plan provides Medicare and [insert name of Medicaid program] services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.]*

*[Plan can include language about itself.]*

---

## B. Information about Medicare and *[Insert name of Medicaid Program]*

### B1. Medicare

Medicare is the federal health insurance program for:

- People 65 years of age or older,
- Some people under age 65 with certain disabilities, **and**
- People with end-stage renal disease (kidney failure).

### B2. *[Insert name of Medicaid Program]*

*[Insert name of the Medicaid program]* is the name of *[insert name of state]* Medicaid program. *[Insert name of Medicaid program]* is run by the state and is paid for by the state and the federal government. *[Insert name of Medicaid program]* helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- What counts as income and resources,
- Who is eligible,
- What services are covered, **and**
- The cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

*[Plans should revise this section to best reflect the coverage of the plan.]* Medicare and the state of *[insert name of state]* approved our plan. You can get Medicare and *[insert name of state Medicaid program]* services through our plan as long as:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We choose to offer the plan, **and**
- Medicare and the State of *[insert name of state]* allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and *[insert name of state program]* services is not affected.

---

## C. Advantages of our plan

*[Plans should revise this section to best reflect the coverage of the plan.]* You will now get all your covered Medicare and *[Insert name of Medicaid program]* services from our plan, including prescription drugs. **You do not pay extra to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **all** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

---

## D. Our plan's service area

*[Insert plan service area here or within an appendix. Include a map if one is available.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Use county name only if approved for entire county, for example: Our service area includes these counties in <State>: <counties>.*

*For an approved partial county, use county name plus approved ZIP code(s) that are excluded, for example: Our service area includes all parts of <county> with the exception of the following ZIP code(s): <ZIP code(s)>.*

*If needed, plans may insert a table with more than one row or a short, bulleted list to describe and illustrate their service area in a way that is easy to understand.]*

Only people who live in our service area can join our plan.

**You cannot stay in our plan if you move outside of our service area.** Refer to **Chapter 8** of your *Member Handbook* for more information about the effects of moving out of our service area.

---

## E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- Live in our service area, **and**
- Have both Medicare Part A and Medicare Part B, **and**
- *Are currently eligible for [insert name of state Medicaid program], and*
- *[Insert any Medicaid requirements], and*
- Are a United States citizen or are lawfully present in the United States.

If you lose eligibility but can be expected to regain it within *[Insert number 1-6. Plans may choose any length of time from one to six months for deeming continued eligibility, as long as they apply the criteria consistently across all members and fully inform members of the policy.]* month(s), then you are still eligible for our plan.

Call Member Services for more information.

---

## F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date *[Plans adjust this language if the state requirement is more stringent]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs [\[add additional areas covered by HRA\]](#).

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

*[\[Plans may add additional language regarding information about joining the plans as directed by the state such as information about a continuity of care period or using doctors for a transition period.\]](#)*

---

## G. Your care team and care plan

### G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, or other health person that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

### G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and [\[Insert as applicable: LTSS or other services\]](#).

Your care plan includes: [\[Update the description of the care plan and the process as outlined in your model of care \(MOC\)\]](#).

- Your health care goals.
- A timeline for getting the services you need.

Your care team meets with you after your health risk assessment. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H. Your monthly costs for *[insert plan name]*

*[Plans should revise this section to only include premium types that apply or delete if plan has no monthly premium and revise with “Our plan has no premium.”]*

Your costs may include the following:

- Plan premium (Section H.1)
- Monthly Medicare Part B Premium (Section H.2)
- Optional Supplemental Benefit Premium (Section H.3)

**In some situations, your plan premium could be less.**

*[Insert as appropriate, depending on whether SPAPs are discussed in Chapter 2: There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. OR The “Extra Help” program helps people with limited resources pay for their drugs.]* Chapter 2, Section H2 tells more about *[insert as applicable: these programs OR this program.]* If you qualify, enrolling in the program might lower your monthly plan premium.

If you *already enrolled* and are getting help from one of these programs, **the information about premiums in this *Member Handbook* *[insert as applicable: may OR does]* not apply to you.** *[If not applicable, omit information about the LIS Rider.]* We *[insert as appropriate: have included OR sent you]* a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

### H1. Plan premium

*[If applicable, plans should revise this section to indicate that the plan premium is paid on behalf of members (e.g. by “Extra Help”, Medicaid).]*

As a member of your plan, you pay a monthly plan premium. *[Select one of the following: For 2024, the monthly premium for *[insert 2024 plan name]* is *[insert monthly premium amount]*. OR The monthly premium amount for *[insert 2024 plan name]* is listed in *[describe attachment.]* *[Plans may insert a list or table with the state/region and monthly plan premium amount for each area included within the EOC. Plans may also include premium(s) in an attachment to the EOC.]**

*[Plans with no premium should delete this section.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H2. Monthly Medicare Part B Premium

### Many members are required to pay other Medicare premiums

*[Plans that include a Medicare Part B premium reduction benefit may describe the benefit within this section.]*

*[Plans that do not have any members paying Medicare premiums or plans whose members must pay the full Medicare Part B premium should modify this section.]*

*[Plans with no monthly premium, omit: In addition to paying the monthly plan premium,]* some members are required to pay other Medicare premiums. As explained in Section H2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most *[insert 2024 plan name]* members, Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and for your Medicare Part B premium.

**If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.** This includes your premium for Medicare Part B. It may also include a premium for Medicare Part A which affects members who aren't eligible for premium free Medicare Part A. **In addition, please contact Member Services or your care coordinator and inform them of this change.**

### H3. Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called "optional supplemental benefits," then you pay additional premium each month for these extra benefits. Refer to Chapter 4, Section E for details. *[If the plan describes optional supplemental benefits within Chapter 4, then the plan must include the premium amounts for those benefits in this section.]*

---

## I. Your Member Handbook

Your *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* found on our website *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

The contract is in effect for the months you are enrolled in our plan between *[insert start date]* and *[insert end date]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, *[insert if applicable: information about how to access]* a *Provider and Pharmacy Directory*, *[plans that limit DME brands and manufacturers insert: a List of Durable Medical Equipment,]* and *[insert if applicable: information about how to access]* a *List of Covered Drugs*, also known as a *Formulary*.

### J1. Your Member ID Card

Under our plan, you have one card for your Medicare and *[insert name of Medicaid program]* services, including long-term services and supports, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:

*[Insert picture of front and back of plan ID card. Mark it as a sample card (for example, by superimposing the word “sample” on the image of the card).]*

If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your *[insert name of Medicaid program]* card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Member Handbook* to find out what to do if you get a bill from a provider.

*[If members must use a different card for any Medicaid services, include a description here.]*

### J2. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Provider and Pharmacy Directory* at *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

*[Plans must add information describing the information available in the directory.]*

*[Plans may add information describing the use of providers during a transition period as directed by the state.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Definition of network providers**

- Our network providers include:
  - Doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - LTSS, behavioral health services, home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

**Definition of network pharmacies**

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to [\[insert if applicable: help you\]](#) pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

[\[Plans that limit DME brands and manufacturers insert the following section \(for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual:](#)

**List of Durable Medical Equipment (DME)**

We sent you our List of Durable Medical Equipment (DME) with this *Member Handbook*. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at the address at the bottom of the page. Refer to **Chapters 3 and 4** of your *Member Handbook* to learn more about DME equipment.]

**J3. List of Covered Drugs**

The plan has a *List of Covered Drugs*. We call it the “Drug List” for short. It tells you which prescription drugs our plan covers.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Member Handbook* for more information.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



Each year, we send you [\[insert if applicable: information about how to access\]](#) the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website [at the address at the bottom of the page](#). [\[Plans may insert information about Medicaid covered drugs.\]](#)

#### J4. The Explanation of Benefits

When you use your Medicare Part D prescription drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D prescription drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take [\[insert, as applicable: such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options\]](#).

**Chapter 6** of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

[\[Plans may insert other methods for members to get their EOB.\]](#)

---

## K. Keeping your membership record up to date

[\[In the Table of Contents, section heading, and text, plans substitute the name for this file if it differs from "membership record."\]](#)

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you.**

Tell us right away about the following:

- Changes to your name, your address, or your phone number.
- Changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation.
- Any liability claims, such as claims from an automobile accident.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Admission to a nursing facility or hospital.
- Care from a hospital or emergency room.
- Changes in your caregiver (or anyone responsible for you.)
- You take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

*[Plans that allow members to update this information online may describe that option here.]*

*[Plans may add information regarding keeping their Medicaid information updated as directed by the state.]*

### **K1. Privacy of personal health information (PHI)**

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 2: Important phone numbers and resources

---

### Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[If applicable, plans should modify this chapter to include contact information for other resources.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## A. Member Services

|                |                                                                                                                                                                                                                                                                                          |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <p>&lt;Phone number(s)&gt; This call is free.</p> <p>&lt;Days and hours of operation&gt; <i>[Include information on the use of alternative technologies.]</i></p> <p>We have free interpreter services for people who do not speak English.</p>                                          |
| <b>TTY</b>     | <p>&lt;TTY phone number&gt; This call is free.</p> <p><i>[Insert if the plan uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i></p> <p>&lt;Days and hours of operation&gt;</p> |
| <b>FAX</b>     | <i>[Fax number is optional.]</i>                                                                                                                                                                                                                                                         |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                                                                                        |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                                                      |
| <b>WEBSITE</b> | <i>[Web URL.]</i>                                                                                                                                                                                                                                                                        |

Contact Member Services to get help with:

- Questions about the plan
- Questions about claims or billing

*[If plans have different numbers for the functions listed below, plans should insert separate charts with the additional contact information.]*

- Coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of your *Member Handbook*.

**Commented [AA1]:** Can these two sentences be combined? Example: To learn more about coverage decisions, refer to Chapter 9 of your member handbook or contact Member Services.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of your *Member Handbook* or contact Member Services.
- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (refer to **Section F** *[insert reference, as applicable]*).
  - You can call us and explain your complaint at <phone number>.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above *[insert reference, as applicable]*).
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - *[Insert additional instructions regarding how to make a complaint as directed by the state.]*
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Member Handbook*.
- Coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**
    - the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs *[insert if applicable, and name of Medicaid program prescription drugs and over-the-counter drugs]*.
  - For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.

Commented [CC2]: recommend change "got" to received

Commented [AA3]: Change "to" to "from"



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above *[insert reference, as applicable]*.)
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Payment for health care or drugs you already paid for

*[Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]*

  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of your *Member Handbook*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B. Your Care Coordinator

**Commented [AA4]:** Flexibility to modify this section

*[Plans should include information explaining what a care coordinator is, how members can get a care coordinator, how they can contact the care coordinator, and how they can change their care coordinator. Plans can modify this section as appropriate.]*

|                |                                                                                                                                                                                                                                                                                                          |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <Phone number(s)> This call is free.<br><br><Days and hours of operation> <i>[Include information on the use of alternative technologies.]</i><br><br>We have free interpreter services for people who do not speak English.                                                                             |
| <b>TTY</b>     | <TTY phone number> This call is <i>[insert if applicable: not]</i> free.<br><br><i>[Insert if the plan uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i><br><br><Days and hours of operation> |
| <b>FAX</b>     | <i>[Fax number is optional.]</i>                                                                                                                                                                                                                                                                         |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                                                                                                        |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                                                                      |
| <b>WEBSITE</b> | <i>[Web address is optional.]</i>                                                                                                                                                                                                                                                                        |

Contact your care coordinator to get help with:

- Questions about your health care
- Questions about getting behavioral health (mental health and substance use disorder) services
- Questions about transportation
- Questions about long-term services and supports (LTSS). LTSS includes *[Plans should insert information describing LTSS coverage.]*
- *[Plans may insert bullets noting additional areas that care coordinators can provide assistance with.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



### C. *[Insert State-specific Name of SHIP Program]*

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In *<insert state>*, the SHIP is called *<State-specific SHIP name>*.

*<Insert state-specific SHIP name>* is not connected with any insurance company or health plan.

|         |                                                                                                                                                                                                                               |
|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CALL    | <i>&lt;Phone number(s)&gt;</i><br><i>&lt;Days and hours of operation&gt;</i>                                                                                                                                                  |
| TTY     | <i>[TTY phone number is optional.]</i><br><i>[Insert if the SHIP uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| WRITE   | <i>&lt;Mailing address&gt;</i>                                                                                                                                                                                                |
| EMAIL   | <i>[Email address is optional.]</i>                                                                                                                                                                                           |
| WEBSITE | <i>&lt;Web address&gt;</i>                                                                                                                                                                                                    |

Contact *<insert name of SHIP program>* for help with:

- Questions about Medicare
- *<State-specific SHIP name>* counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.



**If you have questions**, please call *<plan name>* at *<toll-free phone and TTY numbers>*, *<days and hours of operation>*. The call is free. **For more information**, visit *<web address>*.

## D. Quality Improvement Organization (QIO)

Our state has an organization called <State-specific QIO name>. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. <State-specific QIO name> is not connected with our plan.

|                |                                                                                                                                                                                                                              |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <Phone number(s)>                                                                                                                                                                                                            |
| <b>TTY</b>     | <i>[TTY phone number is optional.]</i><br><i>[Insert if the QIO uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                            |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                          |
| <b>WEBSITE</b> | <Web address>                                                                                                                                                                                                                |

Contact <State-specific QIO name> for help with:

- Questions about your health care rights
- Making a complaint about the care you got if you:
  - have a problem with the quality of care,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## E. 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, or CMS.

|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free, 24 hours a day, 7 days a week.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>TTY</b>     | 1-877-486-2048 This call is free.<br>This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>WEBSITE</b> | <a href="https://www.medicare.gov">medicare.gov</a><br>This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices.<br>It includes helpful websites and phone numbers. It also has documents you can print right from your computer.<br>If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you. |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## F. *[Insert name of Medicaid Program]*

*[Plans must adapt this generic discussion of Medicaid to reflect the name or features of the Medicaid program in the plan's state or states.]*

*[If there are two different agencies handling eligibility and coverage/services, the plan should include both and clarify the role of each.]*

*[Plans must, as appropriate, include additional telephone numbers for Medicaid program assistance.]*

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call <State-specific Medicaid agency>.

*[If applicable, plans may also inform members that they can get information about Medicaid from county resource centers and indicate where members can find contact information for these centers.]*

|                |                                                                                                                                                                                                                                                          |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <i>[Insert state-specific Medicaid agency]</i><br><Days and hours of operation>                                                                                                                                                                          |
| <b>TTY</b>     | <i>[Insert number, if available. Or delete this row.] [Insert if the state Medicaid program uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| <b>WRITE</b>   | <i>&lt;Insert Mailing address&gt;</i>                                                                                                                                                                                                                    |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                      |
| <b>WEBSITE</b> | <a href="http://www.healthcareoptions.dhcs.ca.gov/">www.healthcareoptions.dhcs.ca.gov/</a><br><i>&lt;Insert Web URL&gt;</i>                                                                                                                              |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**G. *[Insert State-specific name for ombudsman program]***

The *<State-specific name for ombudsman program>* works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. *<State-specific name for ombudsman program>* also helps you with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

|                |                                                                                                                                                                                                                                            |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <Phone number(s)><br><Days and hours of operation>                                                                                                                                                                                         |
| <b>TTY</b>     | <i>[TTY phone number is optional.]</i><br><i>[Insert if the ombudsman program uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| <b>WRITE</b>   | <Insert Mailing address>                                                                                                                                                                                                                   |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i><br><a href="mailto:">mailto:</a>                                                                                                                                                                       |
| <b>WEBSITE</b> | <Insert Web URL><br><a href="http://www.dhcs.ca.gov/services/medicaid/Pages/MMCDOfficeoftheOmbudsman.aspx">www.dhcs.ca.gov/services/medicaid/Pages/MMCDOfficeoftheOmbudsman.aspx</a>                                                       |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H. Programs to Help People Pay for Their Prescription Drugs

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

### H1. Extra Help

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything to get this “Extra Help.”

|                |                                                                                                                                                                    |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free, 24 hours a day, 7 days a week.                                                                   |
| <b>TTY</b>     | 1-877-486-2048 This call is free.<br>This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. |
| <b>WEBSITE</b> | <a href="https://www.medicare.gov">medicare.gov</a>                                                                                                                |

*[Plans that have no drug cost sharing may delete this section.]*

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your correct copayment level, or if you already have the evidence, to provide this evidence to us.

- *[Plans should insert process for allowing members to request assistance with obtaining best available evidence, and for providing this evidence.]*
- *[Plans should update this description to accurately reflect the process in this bullet.]* When we receive the evidence showing your copayment level, we will update our system so that you will be charged the correct copayment when you get your next prescription. If you overpay your copayment, we will pay you back. Either we will send a check to you or we will deduct the amount from future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owned by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H2. State Pharmaceutical Assistance Program (SPAP) *[Plans in states without an SPAP or where the SPAP excludes enrollment of dual eligible individuals should delete this section.]*

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Medicare Part D drugs (other than “Extra Help” you still get the 70 percent discount on covered brand name drugs. Also, the plan pays five percent of the cost of brand drugs in the coverage gap. The 70 percent discount and the five percent paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

## H3. AIDS Drug Assistance Program (ADAP)

*[Plans should delete this section if not applicable.]* The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance *[insert state-specific ADAP information.]* Note: to be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of the State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance For information on eligibility criteria, covered drugs, or how to enroll in the program, please call *[insert state-specific ADAP contact information.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## I. Social Security

Social Security determines eligibility and handles enrollment for Medicare. U.S. Citizens and lawful permanent residents who are 65 and older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

|                |                                                                                                                                                                                                                                  |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-772-1213<br>Calls to this number are free.<br>Available 8:00 am to 7:00 pm, Monday through Friday.<br>You can use their automated telephone services to get recorded information and conduct some business 24 hours a day. |
| <b>TTY</b>     | 1-800-325-0778<br>This number is for people who difficulty with hearing or speaking. You must have special telephone equipment to call it.                                                                                       |
| <b>WRITE</b>   | <Insert Mailing address>                                                                                                                                                                                                         |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i><br><a href="mailto:">mailto:</a>                                                                                                                                                             |
| <b>WEBSITE</b> | <a href="http://www.ssa.gov">www.ssa.gov</a>                                                                                                                                                                                     |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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## J. Other resources

*[Plans may insert this section to provide additional information resources, such as county aging and disability resource centers, choice counselors, or area agencies on aging or any other sections as directed by the state. Plans should format consistently with other sections, include a brief description and information about any other resources they add, and update the Table of Contents.]*

**Commented [KG5]:** Question: Are we no longer required to put in information about the Rail Road Board? That is currently part of this section in the non integrated EOC



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

# Chapter 3: Using our plan’s coverage for your health care and other covered services

## Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you are billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number as appropriate. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Information about services and providers

**Services** are health care, long-term services and supports, supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and long-term services and supports (LTSS) are in **Chapter 4** of your *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of your *Member Handbook*.

**Providers** are doctors, nurses, and other people who give you services and care. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain long-term services and supports (LTSS).

**Network providers** are providers who work with our plan. These providers agree to accept our payment *[insert if plan has cost sharing: and your cost sharing amount]* as full payment. *[Plans may delete the next sentence if it is not applicable.]* Network providers bill us directly for care they give you. When you use a network provider, you usually pay *[insert as applicable: nothing or only your share of the cost]* for covered services.

---

## B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and *[Insert name of state-specific Medicaid program]*. This includes behavioral health and long-term services and supports (LTSS).

Our plan will generally pay for health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be a **plan benefit**. This means we include it in our Benefits Chart in **Chapter 4** of your *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise the state-specific definition of "medically necessary" as appropriate and ensure that it is updated and used consistently throughout member material models.]*
- *[Plans may omit or edit the PCP-related bullets as necessary, including modifying the name of the PCP.]* For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another doctor. As a plan member, you must choose a network provider to be your PCP.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- In most cases, *[insert as applicable: your network PCP or our plan]* must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services. To learn more about referrals, refer to page <page number>.
- *[Insert if applicable: Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is [insert definition].]*
- You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, refer to section D1 in this chapter).
- **You must get your care from network providers** *[insert if applicable: that are affiliated with your PCP's medical group]*. Usually, we won't cover care from a provider who doesn't work with our health plan *[insert if applicable: and your PCP's medical group]*. This means that you will have to pay the provider in full for the services furnished. Here are some cases when this rule does not apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to section H in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. *[Plans may specify whether authorization should be obtained before seeking care.]* In this situation, we cover the care *[insert as applicable: as if you got it from a network provider or at no cost to you]*.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility. *[Insert as applicable: The cost sharing you pay for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from an out-of-network provider the cost sharing for the dialysis may be higher.]*

*[Plans add additional exceptions as appropriate including exceptions as required by the state.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## C. Your care coordinator

*[Plans provide applicable information about the care coordinator and care coordination, as well as explanations for the following subsections. Plans should replace the terms “care coordinator” and “care team” with terms they use. If Plans use more than one type of “care coordinator,” multiple descriptions can be provided that describe each type, or additional language can be added to the care coordinator definition below.]*

### C1. What a care coordinator is

*[Example text: A care coordinator is a trained person who works for our plan to provide care coordination services for you.]*

### C2. How you can contact your care coordinator

### C3. How you can change your care coordinator

---

## D. Care from providers

### D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care. *[Insert if applicable: Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group.]*

#### Definition of a PCP and what a PCP does do for you

*[Plans describe the following in the context of their plans:*

*What a PCP is*

*If applicable, what a medical group or IPA is*

*What types of providers may act as a PCP [If a State allows specialists to act as a PCP, plans must inform members of this and under what circumstances a specialist may be a PCP.]*

*The role of a PCP in*

- *Coordinating covered services*
- *Making decisions about or getting prior authorization (PA), if applicable*

*When a clinic can be your PCP (RHC/FQHC)]*

#### Your choice of PCP



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans describe how to choose a PCP. Plans that assign members to medical groups or IPAs must include language that explains how the choice of PCP will affect member access to specialists and hospitals. For example:*

*If there is a particular specialist or hospital that you want to use, find out if they're affiliated with your PCP's medical group. You can look in the [Provider and Pharmacy Directory](#), or ask Member Services to find out if the PCP you want makes referrals to that specialist or uses that hospital.]*

### Option to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

*[Plans describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.).]*

*[Insert if applicable: Our plan's PCPs are affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for a change, tell Member Services if you use a specialist or get other covered services that must have PCP approval. Member Services helps you continue your specialty care and other services when you change your PCP.]*

### Services you can get without approval from your PCP

*[Note: Insert this section only if plans require referrals to network providers.]*

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to a network provider (for example, if you're outside our plan's service area or during the weekend).

**Note:** Urgently needed care must be immediately needed and medically necessary.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccinations *[insert if applicable: as well as hepatitis B vaccinations and pneumonia vaccinations]* *[insert if applicable: as long as you get them from a network provider]*.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams *[insert if applicable: as long as you get them from a network provider]*.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.

*[Plans add additional bullets consistently formatted like the rest of this section as appropriate.]*

## D2. Care from specialists and other network providers

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

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

*[Plans describe how members access specialists and other network providers, including:*

*The role (if any) of the PCP in referring members to specialists and other providers.*

*A description of PA as well as the process for getting PA [Plans explain that PA means the member gets plan approval before getting a specific service or drug or using an out-of-network provider, and plans include information about who makes the PA decision (e.g., Medical Director, the PCP, or another entity).] Refer members to Chapter 4 for information about which services require PA.*

*If PCP selection results in being limited to specific specialists or hospitals to which that PCP refers [For example, plans include information about subnetworks.]]*

*[Plans with referral models, insert: A written referral may be for one visit or it may be a standing referral for more than one visit if you need ongoing services. We must give you a standing referral to a qualified specialist for any of these conditions:*

- A chronic (ongoing) condition;



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- A life-threatening mental or physical illness;
- A degenerative disease or disability;
- Any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a written referral when needed, the bill may not be paid. For more information, call Member Services at the number at the bottom of this page.]

*[Plans with direct access models, insert: If we are unable to find you a qualified plan network provider, we must give you a standing service authorization for a qualified specialist for any of these conditions:*

- A chronic (ongoing) condition;
- A life-threatening mental or physical illness;
- A degenerative disease or disability;
- Any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a service authorization from us when needed, the bill may not be paid. For more information, call Member Services at the phone number printed at the bottom of this page.]

### D3. When a provider leaves our plan

*[Plans may edit this section if Medicaid requires them to have a transition benefit when a provider leaves the plan.]*

A network provider you use may leave our plan. If one of your providers leaves our plan, you have certain rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we work with you to ensure, that the medically necessary treatment you are getting is not interrupted.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to Chapter 9 *[plans may insert reference, as applicable]* for more information.)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. *[Plans include contact information for assistance.]*

#### D4. Out-of-network providers

*[Plans tell members under what circumstances they can get services from out-of-network providers (e.g., when providers of specialized services are not available in network). Include Medicaid out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it.] [Note: members are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover dialysis services for ESRD members who have traveled outside the plans service area or when the provider is temporarily unavailable or not accessible and are not able to access contracted ESRD providers.]*

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or *[Insert name of state-specific Medicaid program]*.

- We cannot pay a provider who is not eligible to participate in Medicare and/or *[Insert name of state-specific Medicaid program]*.
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

---

### E. Long-term services and supports (LTSS)

*[Plans should provide applicable information about getting LTSS.]*

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### F. Behavioral health (mental health and substance use disorder) services

*[Plans should provide applicable information about getting behavioral health services.]*

---

### G. *[If applicable plans should add: How to get self-directed care]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans should provide applicable information about getting self-directed care, including the following subsections.]*

**G1. What self-directed care is**

**G2. Who can get self-directed care (for example, if it is limited to waiver populations)**

**G3. How to get help in employing personal care providers (if applicable)**

---

**H. Transportation services**

*[Plans should provide applicable information about getting transportation services.]*

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**I. Covered services in a medical emergency, when urgently needed, or during a disaster**

**I1. Care in a medical emergency**

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- Serious risk to your health *[insert as applicable: or to that of your unborn child];*  
**or**
- Serious harm to bodily functions; **or**
- Serious dysfunction of any bodily organ or part; **or**
- *[Insert as applicable: In the case of a pregnant woman in active labor, when:*
  - there is not enough time to safely transfer you to another hospital before delivery.
  - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

territories *[insert as applicable: or worldwide]*, from any provider with an appropriate state license.

- *[Plans add if applicable: As soon as possible, tell our plan about your emergency. We follow up on your emergency care. You or someone else [plans may replace "someone else" with "your care coordinator" or other applicable term] should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us.] [Plans must provide the contact phone number and days and hours of operation or explain where to find the information (e.g., on the back of the Member ID Card).]*

### Covered services in a medical emergency

*[Plans that cover emergency medical care outside the United States or its territories through Medicaid may describe this coverage based on the Medicaid program coverage area. Plans must also include language emphasizing that Medicare does not provide coverage for emergency medical care outside the United States and its territories.]*

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

*[Plans may add to this paragraph as needed to include other information about their post-stabilization care.]* Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

### Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

After the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## 12. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need treatment.

### Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it is not possible or reasonable to get to a network provider, we cover urgently needed care you get from an out-of-network provider.

*[Plans must insert instructions for how to access urgently needed services (e.g., using urgent care centers, a provider hotline, etc.).]*

### Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider.

*[Plans that cover urgently needed care outside the United States or its territories through Medicaid may describe this coverage based on the Medicaid program coverage area.]*

Our plan does not cover urgently needed care or any other *[insert if plan covers emergency care outside of the United States and its territories: non-emergency]* care that you get outside the United States.

*[Insert if applicable: Plans with world-wide emergency/urgent coverage as a supplemental benefit: Our plan covers worldwide [insert as applicable: emergency and urgently needed care OR emergency OR urgently needed care] services outside the United States under the following circumstances [insert details.]]*

## 13. Care during a disaster

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

Visit our website for information on how to get care you need during a declared disaster: <web address>. *[In accordance with 42 CFR 422.100(m), plans must include on their web page, at a minimum, information about coverage of benefits at non-contracted facilities at network cost sharing without required PA; terms and conditions of payment for non-contracted providers; and each declared disaster's start and end dates.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at *[insert as applicable: the in-network cost-sharing rate or no cost to you]*. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of your *Member Handbook* for more information.

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## J. What to do if you are billed directly for services our plan covers

*[Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]*

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay *[plans with cost sharing, insert: our share of]* the bill.

**You should not pay the bill yourself. If you do, we may not be able to pay you back.**

*[Insert as applicable: If you paid for your covered services or If you paid more than your plan cost-sharing for covered services]* or if you got a bill for *[plans with cost sharing, insert: the full cost of]* covered medical services, refer to **Chapter 7** of your *Member Handbook* to find out what to do.

### J1. What to do if our plan does not cover services

*[Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]*

Our plan covers all services:

- That are determined medically necessary, **and**
- That are listed in our plan's Benefits Chart (refer to **Chapter 4** of your *Member Handbook*), **and**
- That you get by following plan rules.

If you get services that our plan does not cover, **you pay the full cost yourself.**

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

**Chapter 9** of your *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We pay for some services up to a certain limit. If you use over the limit, you pay the full cost to get more of that type of service. Refer to Chapter 4 for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

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## K. Coverage of health care services in a clinical research study

### K1. Definition of a clinical research study

*[If applicable, plans revise this section to describe Medicaid role in providing coverage and payment for clinical research studies.]*

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare *[plans that conduct or cover clinical trials that are not approved by Medicare, insert: or our plan]* approves a study you want to be in, and you express interest, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

While you're in the study, you may stay enrolled in our plan. That way, our plan continues to cover you for services and care not related to the study.

If you want to take part in any Medicare-approved clinical research study, you do **not** need to tell us or get approval from us *[plans that do not use PCPs may delete the rest of this sentence]* or your primary care provider. Providers that give you care as part of the study do **not** need to be network providers.

#### **We encourage you to tell us before you take part in a clinical research study.**

If you plan to be in a clinical research study, you or your care coordinator should contact Member Services to let us know you will take part in a clinical trial.

### K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- 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 that is part of the research study.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- Treatment of any side effects and complications of the new care.

*[Plans that conduct or cover clinical trials that are not approved by Medicare insert: If you volunteer for a clinical research study, we pay any costs that Medicare does not approve but that our plan approves.]* If you're part of a study that Medicare *[plans that conduct or cover clinical trials that are not approved by Medicare, insert: or our plan]* has **not** approved, you pay any costs for being in the study.

### K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website ([www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf](http://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf)). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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## L. How your health care services are covered in a religious non-medical health care institution

### L1. Definition of a religious non-medical health care institution

*[If applicable, plans revise this section to describe Medicaid's role in providing care in religious non-medical health care institutions.]*

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

### L2. Care from a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you get services from this institution that are provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - *[Omit this bullet if not applicable]* You must get approval from us before you are admitted to the facility, or your stay will **not** be covered.

*[Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Benefits Chart in Chapter 4 *[insert reference, as applicable]*) or whether there is unlimited coverage for this benefit.]*

## M. Durable medical equipment (DME)

### M1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. As a member of our plan, you *[insert if the plan sometimes allows transfer of ownership to the member: usually]* will **not** own DME, no matter how long you rent it.

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*[If the plan allows transfer of ownership of certain DME items to members, the plan must modify this section to explain the conditions and when the member can own specified DME.]*

*[If the plan sometimes allows transfer of ownership to the member for DME items other than prosthetics, insert: In certain limited situations, we transfer ownership of the DME item to you. Call Member Services to find out about requirements you must meet and papers you need to provide.]*

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you will **not** own the equipment.

*[Plans should modify this section as necessary to explain any additional Medicaid coverage of DME.]*

### M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Note:** You can find definitions of Original Medicare and MA Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2023* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you)) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments do not count toward the payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan

### **M3. Oxygen equipment benefits as a member of our plan**

If you qualify for oxygen equipment covered by Medicare and you're a member of our plan, we cover:

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

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

### **M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan**

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- Oxygen equipment, supplies, and services for another 24 months.
- Oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 4: Benefits chart

### Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services *[insert if the plan has cost sharing: and how much you pay for each service]*. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

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**Commented [KG1]:** Comment: Instructions should be updated to state plans can update the content of the Table of Contents as applicable. For Example CC doesn't have an option for members to buy additional supplemental benefits.



**If you have questions**, please call <plan name> at <toll-free phone and TTY/TDD numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 1

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## A. Your covered services *[insert if the plan has cost sharing: and your out-of-pocket costs]*

This chapter tells you about services our plan covers *[insert if the plan has cost-sharing: and how much you pay for each service]*. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your *Member Handbook*. *[Insert if applicable: This chapter also explains limits on some services.]*

*[Plans with cost sharing, insert: For some services, are charged an out-of-pocket cost called a copay. This is a fixed amount (for example, \$5) you pay each time you get that service. You pay the copay at the time you get the medical service.]*

*[Plans with **no** cost-sharing for any services described in this chapter, insert: Because you get assistance from *[Insert name of state-specific Medicaid program]*, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of your *Member Handbook* for details about the plan's rules.]*

If you need help understanding what services are covered, call *[insert: your care coordinator and/or Member Services at <phone number(s)>]*.

*[As applicable, plans insert the subsection heading and information below.]*

### A1. During public health emergencies

*[Plans providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describe the coverage and flexibilities here or include general information about the coverage and flexibilities along with any cross references, as applicable. Plans include whether such coverage and flexibilities are contingent upon the duration of the public health emergency, which may or may not last for the entire year. Plans also include any specific contact information, as applicable, where members can get more details.]*

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## B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

**You should never get a bill from a provider for covered services.** If you do, refer to **Chapter 7** of your *Member Handbook* or call Member Services.

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## C. About our plan's Benefits Chart



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans may add references to long-term care or home and community-based services.]*

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them. *[Plans that include an index at the end of the chapter should insert: To find a service in the chart, you can also use the index at the end of the chapter.]*

**We pay for the services listed in the Benefits Chart when the following rules are met.**

*[Plans that do not have cost-sharing, insert: You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.]*

- We provide covered Medicare and *[Insert name of state-specific Medicaid program]* covered services according to the rules set by Medicare and *[Insert name of state-specific Medicaid program]*.
- The services *[Plans may revise as applicable: (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs)]* must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise and use the state-specific definition of “medically necessary” and ensure that it is updated and used consistently in Chapter 12 and throughout member materials.]*
- *[Insert if applicable: You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your *Member Handbook* has more information about using network and out-of-network providers.]*
- *[Insert if applicable: You have a primary care provider (PCP) or a care team that is providing and managing your care. [Plans that do not require referrals, omit the rest of this paragraph:] In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan’s network. This is called a referral. **Chapter 3** of your *Member Handbook* has more information about getting a referral and when you do **not** need one.]*
- *[Insert if applicable: We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need prior authorization (PA) [insert as appropriate: with an asterisk (\*) or with a*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

footnote **or** in bold type *or* in italic type].] *[Insert if applicable: In addition, you must get prior authorization (PA) for the following services not listed in the Benefits Chart: [insert list].]*

- *[Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI)” in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Members with Certain Chronic Conditions**. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [insert if applicable: and/or reduced cost sharing]:*
  - *[List all applicable chronic conditions here.]*
  - *[If offering SSBCI, include information about the process and/or criteria for determining eligibility for SSBCI. Plan must also deliver a written summary of the SSBCI offered to each chronically ill member eligible for SSBCI.]*

Refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.]

- *[Insert as applicable: Most **or** All]* preventive services are free. You find this apple  next to preventive services in the Benefits Chart.
- *[Insert any additional applicable Medicaid program coverage here such as community supports]*

*[Instructions on completing the Benefits Chart:*

- *For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.*
- *Optional supplemental benefits are not permitted in this chart; optional supplemental benefits should be described in section E.*
- *Include the following where appropriate: Talk to your provider and get a referral.*
- *Plans must include any services provided in excess of the Medicare and Medicaid requirements and identify preventive services with the apple icon.*
- *HMO POS plan types must provide information about which services must be obtained from network providers, which services can be obtained out-of-network under the POS benefit, and any differences in cost sharing for covered services obtained out-of-network under the POS benefit.*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- *Plans should clearly indicate which benefits are subject to prior authorization (PA). (This can be done with asterisks, footnotes, bold type, or italic type. Plans must select only one method of indication, describe it in terms easily understandable by members, make the indication and description prominently visible, and use it consistently throughout the document.)*
- *Plans may insert any additional benefit information that is based on the plan's approved benefit package and not already included in the Benefits Chart or in the exclusions section. Plans insert any additional benefits in the chart alphabetically.*
- *Plans must add any Medicaid benefits covered to the chart as instructed by the state. Insert any additional benefits in the chart alphabetically. If directed by the state, include all non-waiver services in the chart and all HCBS waiver services as a separate section after the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed. The remainder of the sections should then be renumbered.*
- *Plans must describe any restrictive policies, limitations, or monetary limits that might affect a member's access to services within the chart.*
- *Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.*
- *Plans should include all non-waiver LTSS in the chart in alphabetical order.*
- *Plans with no cost sharing for any type of service (i.e., no cost sharing at all) may delete the "what you must pay" column from the table. Plans with any type of cost sharing for services, including for pharmacy services, must leave the "what you must pay" column in the table.*
- *Plans offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:*
  - *Deliver to each clinically-targeted member a written summary of those benefits so that such member are notified of the "Uniformity Flexibility" benefits for which they are eligible.*
  - *Update the Benefits Chart to include details, as applicable, about the exact targeted reduced cost sharing amount for each specific service and/or the additional supplemental benefits being offered.]*

**Commented [KG2]:** Currently Plans are also able to write "Prior Authorization MAY be required" in this section. Is that going to still be allowed?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

D. Our plan’s Benefits Chart

[When a benefit continues from one page to the next, plans enter a blank return before right aligning and inserting at the bottom of the first part of the description: **This benefit is continued on the next page.** At the top of the next page where the benefit description continues, plans enter the benefit name again in bold followed by **(continued)**. Plans may refer to **Durable medical equipment (DME) and related supplies** and other benefits later in this chart as examples. Plans should also be aware that the flow of benefits from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed.]

[Plans should modify this section throughout to reflect Medicaid or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medicaid.]

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                          | What you must pay                                        |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
|  | <p><b>Abdominal aortic aneurysm screening</b></p> <p>We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p> <p>[List any additional benefits offered.]</p> | <p>\$0</p> <p>[List copays for additional benefits.]</p> |

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <p><b>Acupuncture</b></p> <p>We pay for up to 12 acupuncture visits in 90 days <b>if</b> you have chronic low back pain, defined as:</p> <ul style="list-style-type: none"> <li>• lasting 12 weeks or longer;</li> <li>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);</li> <li>• not associated with surgery; <b>and</b></li> <li>• not associated with pregnancy.</li> </ul> <p>In addition, we pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.</p> <p>Acupuncture treatments must be stopped if you don't get better or if you get worse.</p> <p><a href="#">[List any additional benefits offered.]</a></p> | <p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p> |
| <p> <b>Alcohol misuse screening and counseling</b></p> <p>We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.</p> <p>If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.</p> <p><a href="#">[List any additional benefits offered.]</a></p>                                                                                                                                                                                                                                              | <p>\$0</p>                                                               |

**Commented [KG3]:** Should probably say "Only if you have chronic lower back pain"



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | What you must pay                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|
|  <b>Ambulance services</b><br><br>Covered ambulance services include ground, air (airplane and helicopter), and rotary-wing ambulance services. The ambulance will take you to the nearest place that can give you care.<br><br>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases <u>(non-emergent)</u> must be approved by <u>us</u> .<br><br>In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. |  | \$0                                                               |
|  <b>Annual wellness visit</b><br><br>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 <u>months</u> .<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                                                                                                                                                                                                                                                                        |  | \$0                                                               |
|  <b>Bone mass measurement</b><br><br>We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.<br><br>We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                                                        |  | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |

**Commented [KG4]:** This paragraph should be the last paragraph as it sounds like this is for "non emergency" transportation by ambulance.

**Commented [KG5]:** This is different than the current EOC. The current EOC has this caveat "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." Is this caveat still going to apply?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
|  <b>Breast cancer screening (mammograms)</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>One baseline mammogram between the ages of 35 and 39 <i>[plans that only cover ages 65 and older should delete]</i></li> <li>One screening mammogram every 12 months <i>[plans that cover women under 65 should include: for women age 40 and older]</i></li> <li>Clinical breast exams once every 24 months</li> </ul> <i>[List any additional benefits offered.]</i>                                     | \$0<br><i>[List copays for additional benefits.]</i> |
| <b>Cardiac (heart) rehabilitation services</b><br>We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions <del>and have with a</del> doctor's <i>[insert as appropriate: referral or order]</i> .<br>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.                                                                                                                                                                                                                       | \$0                                                  |
|  <b>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</b><br>We pay for one visit a year, or more if medically necessary, with your primary care provider to help lower your risk for heart disease. During the <i>[insert: visit or visits]</i> , your doctor may: <ul style="list-style-type: none"> <li>Discuss aspirin use,</li> <li>Check your blood pressure, <b>and/or</b></li> <li>Give you tips to make sure you are eating well.</li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><i>[List copays for additional benefits.]</i> |

Commented [KG6]: grammar



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
|  <b>Cardiovascular (heart) disease testing</b><br>We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                         | \$0<br><i>[List copays for additional benefits.]</i>                     |
|  <b>Cervical and vaginal cancer screening</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>For all women: Pap tests and pelvic exams once every 24 months</li> <li>For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months</li> <li><i>[Plans that cover women under 65 must include: For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months]</i></li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><i>[List copays for additional benefits.]</i>                     |
| <b>Chiropractic services</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>Adjustments of the spine to correct alignment</li> </ul> <i>[List any Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.]</i>                                                                                                                                                                                                                                                                                                                         | <i>[List copays.]</i><br><i>[List copays for supplemental benefits.]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
|  <b>Colorectal cancer screening</b><br>For people 50 and older, we pay for the following services: <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema) every 48 months</li> <li>• Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months</li> <li>• DNA based colorectal screening, every 3 years</li> <li>• Screening Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy)</li> <li>• Screening Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months.</li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><br><i>[List copays for additional benefits.]</i>                        |
| <i>[Include row if applicable and modify to accurately describe the Medicaid and/or supplemental benefit offered.]</i><br><b>Dental services</b><br>Certain dental services, including cleanings, fillings, and dentures, are available through the <i>[insert name of Medicaid program or integrated name]</i> Dental Program.<br><i>[Plans that offer optional supplemental dental benefits insert: Note: Our plan offers additional dental services. Got to Benefits Chart in Section E for more information.]</i>                                                                                                                                                                                                                                 | <i>[If plan offers supplemental benefit, the maximum copay amount is \$10.]</i> |
|  <b>Depression screening</b><br>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                                                                                                                                                                             | \$0<br><br><i>[List copays for additional benefits.]</i>                        |

**Commented [KG7]:** Is there a reason "can provide follow up treatment and/or referrals" was removed? Many primary care settings do the screening and then make a referral for treatment they don't always provide the treatment. Suggest adding "Or" back in.



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| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <div data-bbox="154 464 191 506"></div> <div data-bbox="207 470 415 499"><b>Diabetes screening</b></div> <div data-bbox="207 520 824 575">We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</div> <div data-bbox="215 590 781 764"><ul style="list-style-type: none"><li>• High blood pressure (hypertension)</li><li>• History of abnormal cholesterol and triglyceride levels (dyslipidemia)</li><li>• Obesity</li><li>• History of high blood sugar (glucose)</li></ul></div> <div data-bbox="207 779 821 833">Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.</div> <div data-bbox="207 848 795 903">Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.</div> <div data-bbox="207 917 568 940"><a href="#">[List any additional benefits offered.]</a></div> | <div data-bbox="878 470 911 495">\$0</div> <div data-bbox="878 512 1076 567"><a href="#">[List copays for additional benefits.]</a></div> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <div data-bbox="154 462 194 514"></div> <div data-bbox="211 472 828 504"><b>Diabetic self-management training, services, and supplies</b></div> <p data-bbox="211 514 828 577">We pay for the following services for all people who have diabetes (whether they use insulin or not):</p> <ul data-bbox="211 588 828 1218" style="list-style-type: none"><li data-bbox="211 588 828 840">• Supplies to monitor your blood glucose, including the following:<ul data-bbox="243 651 828 840" style="list-style-type: none"><li data-bbox="243 651 828 682">○ A blood glucose monitor</li><li data-bbox="243 693 828 724">○ Blood glucose test strips</li><li data-bbox="243 735 828 766">○ Lancet devices and lancets</li><li data-bbox="243 777 828 840">○ Glucose-control solutions for checking the accuracy of test strips and monitors</li></ul></li><li data-bbox="211 850 828 1134">• For people with diabetes who have severe diabetic foot disease, we pay for the following:<ul data-bbox="243 913 828 1134" style="list-style-type: none"><li data-bbox="243 913 828 1008">○ One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, <b>or</b></li><li data-bbox="243 1018 828 1134">○ One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)</li></ul></li><li data-bbox="211 1144 828 1218">• In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.</li></ul> <p data-bbox="211 1228 828 1260"><a href="#">[List any additional benefits offered.]</a></p> | <p data-bbox="876 472 1136 504">\$0</p> <p data-bbox="876 514 1136 577"><a href="#">[List copays for additional benefits.]</a></p> |



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| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Durable medical equipment (DME) and related supplies</b></p> <p>Refer to Chapter 12 of your <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).”</p> <p>We cover the following items:</p> <ul style="list-style-type: none"> <li>• Wheelchairs</li> <li>• Crutches</li> <li>• Powered mattress systems</li> <li>• Diabetic supplies</li> <li>• Hospital beds ordered by a provider for use in the home</li> <li>• Intravenous (IV) infusion pumps and pole</li> <li>• Speech generating devices</li> <li>• Oxygen equipment and supplies</li> <li>• Nebulizers</li> <li>• Walkers</li> <li>• Standard curved handle or quad cane and replacement supplies</li> <li>• Cervical traction (over the door)</li> <li>• Bone stimulator</li> <li>• Dialysis care equipment</li> </ul> <p>Other items may be covered.</p> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays, including how they vary for equipment covered by Medicare and Medicaid, if applicable.]</i></p> <p><i>[Include if applicable: Your cost sharing for Medicare oxygen equipment coverage is [insert copay amount or coinsurance percentage], every [insert required frequency of payment].]</i></p> <p><i>[Plans that use a constant cost-sharing structure for oxygen equipment insert: Your cost sharing will not change after being enrolled for 36 months.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay                                                                                                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Durable medical equipment (DME) and related supplies (continued)</b></p> <p><i>[Plans that do not limit the DME brands and manufacturers that they cover, insert: We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.]</i></p> <p><i>[Plans that limit the DME brands and manufacturers that they cover, insert the following (for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual): With this Member Handbook, we sent you our plan's list of DME. The list tells you the brands and makers of DME that we pay for. You may also find the most recent list of brands, makers, and suppliers on our website at &lt;URL&gt;.</i></p> <p>Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We do not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to our plan and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)</p> <p>If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor may file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is right for your medical condition. For more information about appeals, refer to <b>Chapter 9</b> of your <i>Member Handbook</i>.]</p> | <p><i>[Plans that wish to vary cost sharing for oxygen equipment after 36 months insert details including whether original cost sharing resumes after 5 years and you are still in the plan.] [If cost sharing is different for members who made 36 months of rental payments prior to joining the plan insert: If prior to enrolling in [insert plan name] is [insert cost sharing].]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Emergency care</b></p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> <li>Given by a provider trained to give emergency services, <b>and</b></li> <li>Needed to treat a medical emergency.</li> </ul> <p>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> <li>Serious risk to your health <i>[Plans that cover women under 65 must include: or to that of your unborn child]; or</i></li> <li>Serious harm to bodily functions; <b>or</b></li> <li>Serious dysfunction of any bodily organ or part; <b>or</b></li> <li><i>[Plans that cover women under 65 must include: In the case of a pregnant woman in active labor, when:</i> <ul style="list-style-type: none"> <li>There is not enough time to safely transfer you to another hospital before delivery.</li> <li>A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]</li> </ul> </li> </ul> <p><i>[Also identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.]</i></p> | <p>\$0</p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, <i>[plans should insert information as needed to accurately describe emergency care benefits: (e.g., you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.)]</i>.</p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
| <p><i>[If family planning services are covered, plans should modify this as necessary.]</i></p> <p><b>Family planning services</b></p> <p>The law lets you choose any provider for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Family planning exam and medical treatment</li> <li>• Family planning lab and diagnostic tests</li> <li>• Family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring)</li> <li>• Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)</li> <li>• Counseling and diagnosis of infertility and related services</li> <li>• Counseling, testing, and treatment for sexually transmitted infections (STIs)</li> <li>• Counseling and testing for HIV and AIDS, and other HIV-related conditions</li> <li>• Permanent Contraception (You must be age 21 or older to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.)</li> <li>• Genetic counseling</li> </ul> <p>We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:</p> <ul style="list-style-type: none"> <li>• Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)</li> <li>• Treatment for AIDS and other HIV-related conditions</li> <li>• Genetic testing</li> </ul> | <p><i>[List copays.]</i></p> |

**Commented [PJ8]:** Should we clarify that this can be a provider who is either In network or Out of network ?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
|  <b>Health and wellness education programs</b><br><i>[These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness and stress management. Describe the nature of the programs here.]</i><br><i>[If this benefit is not applicable, plans should delete this row.]</i>                                                                                                                                                                                                             | <i>[List copays.]</i>                                                  |
| <i>[Plans should modify this section to reflect plan-covered benefits as appropriate.]</i><br><b>Hearing services</b><br>We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.                                                                                                                                                                                                                                                                                                                                                                | <i>[List copays.]</i><br><i>[List copays for additional benefits.]</i> |
| <i>[If this benefit is not applicable, plans should delete this row.]</i><br><b>Help with certain chronic conditions</b><br><i>[Plans that offer targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI),” which members with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits and (as applicable) reduced cost sharing. If offering SSBCI, plans must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package submission.]</i> | <i>[List copays.]</i>                                                  |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
|  <b>HIV screening</b><br>We pay for one HIV screening exam every 12 months for people who: <ul style="list-style-type: none"> <li>• Ask for an HIV screening test, <b>or</b></li> <li>• Are at increased risk for HIV infection.</li> </ul> For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.<br><a href="#">[List any additional benefits offered.]</a>                                                                                                                                                                                                                                                                                                                                                                                                                                    | \$0<br><a href="#">[List copays for additional benefits.]</a> |
| <b>Home health agency care</b><br><a href="#">[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</a><br>Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort.<br>We pay for the following services, and maybe other services not listed here: <ul style="list-style-type: none"> <li>• 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.)</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> </ul> | <a href="#">[List copays.]</a>                                |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                                                                   |
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| <p><b>Home infusion therapy</b></p> <p>Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:</p> <ul style="list-style-type: none"> <li>• The drug or biological substance, such as an antiviral or immune globulin;</li> <li>• Equipment, such as a pump; <b>and</b></li> <li>• Supplies, such as tubing or a catheter.</li> </ul> <p>Our plan covers home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Professional services, including nursing services, provided in accordance with your care plan;</li> <li>• Member training and education not already included in the DME benefit;</li> <li>• Remote monitoring; <b>and</b></li> <li>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.</li> </ul> <p><a href="#">[List any additional benefits offered.]</a></p> | <p><a href="#">[List copays.]</a></p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                                                                                    |
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| <p><b>Hospice care</b></p> <p>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Our plan pays for the following while you get hospice services:</p> <ul style="list-style-type: none"> <li>• Drugs to treat symptoms and pain</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul> <p><b>Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.</b></p> <ul style="list-style-type: none"> <li>• Refer to <b>Section F</b> of this chapter for more information.</li> </ul> <p><b>For services covered by our plan but not covered by Medicare Part A or Medicare Part B:</b></p> <ul style="list-style-type: none"> <li>• Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay <i>[insert as appropriate: our plan's cost-sharing amount or nothing]</i> for these services.</li> </ul> <p><b>For drugs that may be covered by our plan's Medicare Part D benefit:</b></p> <ul style="list-style-type: none"> <li>• Drugs are never covered by both hospice and our plan at the same time. For more information, refer to <b>Chapter 5</b> of your <i>Member Handbook</i>.</li> </ul> <p><b>Note:</b> If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that is <b>not</b> related to your terminal prognosis.</p> <p><i>[Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.]</i></p> | <p><i>[List copays.]</i></p> <p><i>[Include information about cost sharing for hospice consultation services if applicable.]</i></p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                                 |
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|  | <b>Immunizations</b><br><br>We pay for the following services: <ul style="list-style-type: none"><li>• Pneumonia vaccine</li><li>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary</li><li>• Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B</li><li>• COVID-19 vaccines</li><li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li></ul> We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to <b>Chapter 6</b> of your <i>Member Handbook</i> to learn more.<br><br><a href="#">[List any additional benefits offered.]</a> | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                    |
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| <p><b>Inpatient hospital care</b></p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p><i>[List any restrictions that apply.]</i></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units, such as intensive care or coronary care units</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Needed surgical and medical supplies</li> <li>• Appliances, such as wheelchairs</li> <li>• Operating and recovery room services</li> <li>• Physical, occupational, and speech therapy</li> <li>• Inpatient substance abuse services</li> <li>• In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><b>\$0</b></p> <p>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.</p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay |
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| <p><b>Inpatient hospital care (continued)</b></p> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. <i>[Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.]</i></p> <ul style="list-style-type: none"> <li>• Blood, including storage and administration</li> <li>• Physician services</li> </ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are you a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> |                   |
| <p><b>Inpatient services in a psychiatric hospital</b></p> <p>We pay for mental health care services that require a hospital stay. <i>[List days covered, restrictions such as 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.]</i></p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay |
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| <p><i>[Plans with no day limitations on a plan's hospital or nursing facility coverage may modify or delete this row as appropriate.]</i></p> <p><b>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</b></p> <p>We do not pay for your inpatient stay if it is not reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Doctor services</li> <li>• Diagnostic tests, like lab tests</li> <li>• X-ray, radium, and isotope therapy, including technician materials and services</li> <li>• Surgical dressings</li> <li>• Splints, casts, and other devices used for fractures and dislocations</li> <li>• Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: <ul style="list-style-type: none"> <li>○ An internal body organ (including contiguous tissue), <b>or</b></li> <li>○ The function of an inoperative or malfunctioning internal body organ.</li> </ul> </li> <li>• Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition</li> <li>• Physical therapy, speech therapy, and occupational therapy</li> </ul> | <p>\$0</p>        |

**Commented [KG9]:** The previous language was clearer: "If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF)."



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay |
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| <p><b>Kidney disease services and supplies</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services.</li><li>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in <b>Chapter 3</b> of your <i>Member Handbook</i>, or when your provider for this service is temporarily unavailable or inaccessible.</li><li>• Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care</li><li>• Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments</li><li>• Home dialysis equipment and supplies</li><li>• Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply.</li></ul> <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.</p> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay                                               |
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|  <p><b>Lung cancer screening</b></p> <p>Our plan pays for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> <li>• Are aged 50-77, <b>and</b></li> <li>• Have a counseling and shared decision-making visit with your doctor or other qualified provider, <b>and</b></li> <li>• Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.</li> </ul> <p>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.</p> <p><i>[Modify section to accurately describe benefits and list any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                           | <p>\$0</p>                                                      |
|  <p><b>Medical nutrition therapy</b></p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when <i>[insert as appropriate: referred or ordered]</i> by your doctor.</p> <p>We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.</p> <p>We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's <i>[insert as appropriate: referral or order]</i>. A doctor must prescribe these services and renew the <i>[insert as appropriate: referral or order]</i> each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | What you must pay |
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|  <b>Medicare Diabetes Prevention Program (MDPP)</b><br>Our plans pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: <ul style="list-style-type: none"> <li>• Long-term dietary change, <b>and</b></li> <li>• Increased physical activity, <b>and</b></li> <li>• Ways to maintain weight loss and a healthy lifestyle.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$0               |
| <b>Medicare Part B prescription drugs</b><br><i>[Plans that do or expect to use Medicare Part B step therapy should indicate the Medicare Part B drug categories below that are or may be subject to Medicare Part B step therapy as well as a link to a list of drugs subject to Medicare Part B step therapy. Plans may update the link throughout the year and add any changes at least 30 days prior to implementation per 42 CFR 422.111(d).]</i><br>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: <ul style="list-style-type: none"> <li>• Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <li>• Osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay |
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| <p><b>Medicare Part B prescription drugs (continued)</b></p> <ul style="list-style-type: none"> <li>Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents <i>[plans may delete any of the following drugs that they do not not cover]</i> (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</li> <li>IV immune globulin for the home treatment of primary immune deficiency diseases</li> </ul> <p><i>[Insert if applicable: The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: &lt;hyperlink&gt;.]</i></p> <p>We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit.</p> <p><b>Chapter 5</b> of your <i>Member Handbook</i> explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p><b>Chapter 6</b> of your <i>Member Handbook</i> explains what you pay for your outpatient prescription drugs through our plan.</p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay            |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate or eliminate this section if not covered.]</i></p> <p><b>Nursing facility care</b></p> <p>A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital.</p> <p>Services that we pay for include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Nursing services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Respiratory therapy</li> <li>• Drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)</li> <li>• Blood, including storage and administration</li> <li>• Medical and surgical supplies usually given by nursing facilities</li> <li>• Lab tests usually given by nursing facilities</li> <li>• X-rays and other radiology services usually given by nursing facilities</li> <li>• Use of appliances, such as wheelchairs usually given by nursing facilities</li> <li>• Physician/practitioner services</li> <li>• Durable medical equipment</li> <li>• Dental services, including dentures</li> <li>• Vision benefits</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                               |
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| <p><b>Nursing facility care (continued)</b></p> <ul style="list-style-type: none"> <li>• Hearing exams</li> <li>• Chiropractic care</li> <li>• Podiatry services</li> </ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> <li>• A nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care).</li> <li>• A nursing facility where your spouse or domestic partner is living at the time you leave the hospital.</li> </ul> |                                                                 |
| <p> <b>Obesity screening and therapy to keep weight down</b></p> <p>If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                         | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
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| <p><b>Opioid treatment program (OTP) services</b></p> <p>Our plan pays for the following services to treat opioid use disorder (OUD):</p> <ul style="list-style-type: none"> <li>• Intake activities</li> <li>• Periodic assessments</li> <li>• Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications</li> <li>• Substance use counseling</li> <li>• Individual and group therapy</li> <li>• Testing for drugs or chemicals in your body (toxicology testing)</li> </ul> <p><i>[List any other medically necessary treatment or additional benefits offered, with the exception of meals and transportation.]</i></p> | \$0               |
| <p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy, including technician materials and supplies</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts, and other devices used for fractures and dislocations</li> <li>• Lab tests</li> <li>• Blood, including storage and administration</li> <li>• Other outpatient diagnostic tests</li> </ul> <p><i>[Plans can include other covered tests as appropriate.]</i></p>                   | \$0               |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay                                               |
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| <p><b>Outpatient hospital services</b></p> <p>We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services <ul style="list-style-type: none"> <li>○ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.”</li> <li>○ Sometimes you can be in the hospital overnight and still be “outpatient.”</li> <li>○ You can get more information about being inpatient or outpatient in this fact sheet: <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a></li> </ul> </li> <li>• Labs and diagnostic tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies, such as splints and casts</li> <li>• Preventive screenings and services listed throughout the Benefits Chart</li> <li>• Some drugs that you can’t give yourself</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay                                               |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient mental health care</b></p> <p>We pay for mental health services provided by:</p> <ul style="list-style-type: none"> <li>• A state-licensed psychiatrist or doctor</li> <li>• A clinical psychologist</li> <li>• A clinical social worker</li> <li>• A clinical nurse specialist</li> <li>• A nurse practitioner</li> <li>• A physician assistant</li> <li>• Any other Medicare-qualified mental health care professional as allowed under applicable state laws</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient rehabilitation services</b></p> <p>We pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p>                                                                                                                                                                                                       | <p>\$0</p>                                                      |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
| <p><b>Outpatient substance abuse services</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Alcohol misuse screening and counseling</li> <li>• Treatment of drug abuse</li> <li>• Group or individual counseling by a qualified clinician</li> <li>• Subacute detoxification in a residential addiction program</li> <li>• Alcohol and/or drug services in an intensive outpatient treatment center</li> <li>• Extended-release Naltrexone (vivitrol) treatment</li> </ul> <p><i>[Modify this list accurately describe benefits offered or add any additional benefits offered.]</i></p>                                                                                        | <p><i>[List copays.]</i></p> |
| <p><b>Outpatient surgery</b></p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p>                   |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Partial hospitalization services</b></p> <p>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.</p> <p><i>[Network plans that do not have an in-network community mental health center may add: <b>Note:</b> Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.]</i></p> | <p>\$0</p>                   |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | What you must pay                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <p><b>Physician/provider services, including doctor's office visits</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Medically necessary health care or surgery services given in places such as:</li><li>• Physician's office</li><li>• Certified ambulatory surgical center</li><li>• Hospital outpatient department</li><li>• Consultation, diagnosis, and treatment by a specialist</li><li>• Basic hearing and balance exams given by your <i>[insert as applicable: primary care provider or specialist]</i>, if your doctor orders them to find out whether you need treatment</li><li>• <i>[Insert if providing any additional telehealth benefits consistent with 42 CFR § 422.135 in the plan's approved Plan Benefit Package submission: Certain telehealth services, including [insert general description of covered additional telehealth benefits (i.e., the specific Medicare Part B service(s) the plan has identified as clinically appropriate for offering through electronic exchange when the provider is not in the same location as the member). Plans may refer members to their medical coverage policy here].]</i></li></ul> <p><b>This benefit is continued on the next page</b></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>○ 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. <i>[Plans may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.]</i></li> <li>○ <i>[List the available means of electronic exchange used for each Medicare Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.]</i></li> <li>• <i>[Insert if the plan's service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act: Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare]</i></li> <li>• Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home</li> <li>• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke</li> <li>• Telehealth services for members with a substance use disorder or co-occurring mental health disorder</li> </ul> <p><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> <li>○ You have an in-person visit within 6 months prior to your first telehealth visit</li> <li>○ You have an in-person visit every 12 months while receiving these telehealth services</li> <li>○ Exceptions can be made to the above for certain circumstances</li> </ul> </li> <li>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.</li> <li>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b> <ul style="list-style-type: none"> <li>○ you're not a new patient <b>and</b></li> <li>○ The check-in isn't related to an office visit in the past 7 days and</li> <li>○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> <li>• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours <b>if</b>: <ul style="list-style-type: none"> <li>○ you're not a new patient and</li> <li>○ The evaluation isn't related to an office visit in the past 7 days <b>and</b></li> <li>○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> </ul> <p><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay                                               |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient</li> <li>• Second opinion <i>[insert if appropriate: by another network provider]</i> before surgery</li> <li>• Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> <li>○ Surgery of the jaw or related structures</li> <li>○ Setting fractures of the jaw or facial bones</li> <li>○ Pulling teeth before radiation treatments of neoplastic cancer</li> <li>○ Services that would be covered when provided by a physician</li> </ul> </li> </ul> <p><i>[List any additional benefits offered.]</i></p> |                                                                 |
| <p><b>Podiatry services</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)</li> <li>• Routine foot care for members with conditions affecting the legs, such as diabetes</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p> <b>Prostate cancer screening exams</b></p> <p><i>[Plans that cover men under age 65 must include: For men age 50 and older,]</i> we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> <li>• A digital rectal exam</li> <li>• A prostate specific antigen (PSA) test</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Prosthetic devices and related supplies</b></p> <p>Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> <li>• Colostomy bags and supplies related to colostomy care</li> <li>• Pacemakers</li> <li>• Braces</li> <li>• Prosthetic shoes</li> <li>• Artificial arms and legs</li> <li>• Breast prostheses (including a surgical brassiere after a mastectomy)</li> </ul> <p>We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.</p> <p><i>[Plans that pay for prosthetic dental devices, delete the following sentence:]</i> We will not pay for prosthetic dental devices.</p> | <p>\$0</p>                                                      |
| <p><b>Pulmonary rehabilitation services</b></p> <p>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have <i>[insert as appropriate: a referral or an order]</i> for pulmonary rehabilitation from the doctor or provider treating the COPD.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <div data-bbox="154 468 191 506"></div> <div data-bbox="207 468 860 531"><b>Sexually transmitted infections (STIs) screening and counseling</b></div> <div data-bbox="207 548 860 747"><p>We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered <a href="#">[plans that cover women under age 65 should include: for pregnant women and]</a> for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.</p><p>We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.</p><p><a href="#">[Also list any additional benefits offered.]</a></p></div> | <div data-bbox="876 468 1104 569">\$0<br/><a href="#">[List copays for additional benefits.]</a></div> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | What you must pay |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Skilled nursing facility (SNF) care</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"><li>• A semi-private room, or a private room if it is medically necessary</li><li>• Meals, including special diets</li><li>• Nursing services</li><li>• Physical therapy, occupational therapy, and speech therapy</li><li>• Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors</li><li>• Blood, including storage and administration</li><li>• Medical and surgical supplies given by nursing facilities</li><li>• Lab tests given by nursing facilities</li><li>• X-rays and other radiology services given by nursing facilities</li><li>• Appliances, such as wheelchairs, usually given by nursing facilities</li><li>• Physician/provider services</li></ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"><li>• A nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)</li><li>• A nursing facility where your spouse or domestic partner lives at the time you leave the hospital</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
|  <b>Smoking and tobacco use cessation</b><br><br>If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit: <ul style="list-style-type: none"><li>• We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.</li></ul><br>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: <ul style="list-style-type: none"><li>• We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</li></ul><br><a href="#">[List any additional benefits offered.]</a> | \$0<br><br><a href="#">[List copays for supplemental benefits.]</a> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Supervised exercise therapy (SET)</b></p> <p>We pay for SET for members with symptomatic peripheral artery disease (PAD) <i>[insert if applicable: who have a referral for PAD from the physician responsible for PAD treatment]</i>.</p> <p>Our plan pays for:</p> <ul style="list-style-type: none"><li>• Up to 36 sessions during a 12-week period if all SET requirements are met</li><li>• An additional 36 sessions over time if deemed medically necessary by a health care provider</li></ul> <p>The SET program must be:</p> <ul style="list-style-type: none"><li>• 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)</li><li>• In a hospital outpatient setting or in a physician's office</li><li>• Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD</li><li>• Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Urgently needed care</b></p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"> <li>• A non-emergency that requires immediate medical care, <b>or</b></li> <li>• A sudden medical illness, <b>or</b></li> <li>• An injury, <b>or</b></li> <li>• A condition that needs care right away.</li> </ul> <p>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or during the weekend).</p> <p><i>[Include in-network benefits. Also identify whether this coverage is within the U.S. and its territories or is supplemental world-wide emergency/urgent coverage.]</i></p> | <p>\$0</p>        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay                                                          |
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|  <i>[Plans should modify this section to reflect Medicaid and plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]</i><br><b>Vision care</b><br><br>We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.<br><br>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: <ul style="list-style-type: none"><li>• People with a family history of glaucoma</li><li>• People with diabetes</li><li>• African-Americans <i>[plans that cover under 65 must include: who are age 50 and older]</i></li><li>• Hispanic Americans <i>[plans that cover under 65 must include: who are 65 or older]</i></li></ul> <i>[Plans should modify this description if the plan offers more than is covered by Medicare.]</i> We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.<br><br>If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery. | <i>[List copays.]</i><br><br><i>[List copays for additional benefits.]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
|  <p><b>“Welcome to Medicare” preventive visit</b></p> <p>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> <li>• A review of your health,</li> <li>• Education and counseling about the preventive services you need (including screenings and shots), <b>and</b></li> <li>• Referrals for other care if you need it.</li> </ul> <p><b>Note:</b> We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.</p> | \$0               |

## E. Extra “Optional Supplemental” benefits you can buy

*[Include this section if you offer optional supplemental benefits in the plan and describe benefits below. Plans must explain how these benefits are different than what is covered under Medicaid and must indicate if any of the optional supplemental benefits are covered by Medicaid. You may include this section either in the Member Handbook or as an insert to the Member Handbook.]*

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package. These extra benefits are called “**Optional Supplemental Benefits**.” If you want these optional supplemental benefits, you must sign up for them *[insert if applicable: and you may have to pay an additional premium for them.]* The optional supplemental benefits described in *[insert as applicable: this section OR the enclosed insert]* are subject to the same appeals process as any other benefits.

*[Insert plan specific optional supplemental benefits, premiums, deductible, copays, and coinsurance and rules using a chart like the Benefits Chart above. Insert plan specific procedures on how to elect optional supplemental coverage, including application process and effective dates and on how to discontinue optional supplemental coverage, including refund of premiums. Also, insert any restrictions on members’ re-applying for optional supplemental coverage (e.g., must wait until next annual enrollment period).]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## F. Our plan's visitor or traveler benefits

*[If your plan offers a visitor/traveler program to members who are out of your service area, insert this section, adapting and expanding the following paragraphs as needed to describe the traveler benefits and rules related to getting the out-of-area coverage. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR §422.74(b)(4)(iii) (for more than 6 months up to 12 months), also explain that here based on the language suggested below:]*

If you are out of the plan's service area for more than 6 months at a time but do not permanently move, we usually must disenroll you from our plan. However, we offer a visitor/traveler program *[specify areas where the visitor/traveler program is being offered]* that allows you to remain enrolled in our plan when you are outside of our service area for up to 12 months. Under our visitor/traveler program, you get all plan-covered services at in-network cost-sharing prices. Contact us for help in finding a provider when you use the visitor/traveler benefit.

If you are in a visitor/traveler area, you can stay enrolled in the plan until <end date>. If you don't return to our plan's service area by <end date>, we will end your membership in our plan.]

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## G. Benefits covered outside of our plan

*[Plans should modify this section to include additional benefits covered outside the plan by Medicaid fee-for-service and/or a Medicaid managed care plan, as appropriate.]*

We don't cover the following services, but they are available through Medicare or *[insert name state-specific name of Medicaid program]*.

### G1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

#### **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis**

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

#### **For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

#### For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook*.

**Note:** If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care not related to your terminal prognosis.

## H. Benefits not covered by our plan, Medicare, or *[insert name of state-specific Medicaid program]*.

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medicaid do not for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan does not cover the following items and services:

*[The services listed in the remaining bullets are excluded from Medicare's and Medicaid's benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Medicaid or have become covered due to a Medicare or Medicaid change in coverage policy, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans may add parenthetical references to the Benefits Chart for descriptions of covered services and items as appropriate. Plans may also add exclusions as needed.]*

- Services considered not "reasonable and medically necessary," according to Medicare and *[insert name state-specific name of Medicaid program]* standards, unless we list these as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them.

**Commented [AA10]:** The previous chart found in the CY2023 DSNP EOCs which outlines what is not covered under any condition or under certain conditions is more "user" friendly and easier to read. Suggest using the CY2023 formatting for this section.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Refer to **Chapter 3** of your *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it.
- A private room in a hospital, except when medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- *[Plans should delete this if the state allows:]* Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines.
- Routine foot care, except as described in Podiatry services in the Benefits Chart in Section D.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- *[Plans delete this if supplemental:]* Regular hearing exams, hearing aids, or exams to fit hearing aids.
- *[Plans delete this if supplemental:]* Radial keratotomy, LASIK surgery, and other low-vision aids.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. [\[Zero cost-sharing plans may adjust this language as applicable\]](#) However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 5: Getting your outpatient prescription drugs

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### Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and [\[Insert name of Medicaid program\]](#). [\[Plans with no cost sharing, delete the next sentence.\]](#) **Chapter 6** of your *Member Handbook* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

We also cover the following drugs, although they are not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please refer to Chapter 5, Section F "If you are in a Medicare-certified hospice program."

### Rules for our plan's outpatient drug coverage

[\[If coverage includes Medicaid drugs, please add language as needed for Medicaid.\]](#) We usually cover your drugs as long as you follow the rules in this section.

You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). [\[Plans may modify or delete the next sentence as appropriate.\]](#) It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists [\[insert as applicable: or any similar Medicaid lists\]](#).

You generally must use a network pharmacy to fill your prescription.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "Drug List" for short.

- If it is not on the Drug List, we may be able to cover it by giving you an exception.
- Refer to Chapter 9 *[insert reference, as applicable]* to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration or supported by certain medical references. Your doctor may be able to help identify medical references to support the requested use of the prescribed drug. *[Plans should add definition of "medically accepted indication" as appropriate for Medicaid-covered drugs and items.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 2

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## A. Getting your prescriptions filled

### A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website or contact Member Services [\[insert if applicable: or your care coordinator\]](#).

### A2. Using your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy bills us for [\[plans with cost-sharing, insert: our share of the cost of\]](#) your covered prescription drug. [\[Plans with no cost-sharing, delete the next sentence:\]](#) You may need to pay the pharmacy a copay when you pick up your prescription.

If you don't have your plan ID card with you when you fill your prescription, ask the pharmacy to call us to get the necessary 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. Then you can ask us to pay you back [\[insert if the plan has cost-sharing: for our share\]](#). **If you can't pay for the drug, contact Member Services right away.** We will do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of your *Member Handbook*.
- If you need help getting a prescription filled, contact Member Services [\[insert if applicable: or your care coordinator\]](#).

### A3. What to do if you change your network pharmacy

[\[Plans in which members do not need to take any action to change their pharmacies may delete the following sentence.\]](#) If you change pharmacies and need a prescription refill, you can [\[insert as applicable: either ask to have a new prescription written by a provider or\]](#) ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services [\[insert if applicable: or your care coordinator\]](#).

### A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services [\[insert if applicable: or your care coordinator\]](#).



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy. *[Plans may insert additional information about home infusion pharmacy services in the plan's network.]*
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services. *[Plans may insert additional information about LTC pharmacy services in the plan's network.]*
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies. *[Plans may insert additional information about I/T/U pharmacy services in the plan's network.]*
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services *[insert if applicable: or your care coordinator]*.

## A6. Using mail-order services to get your drugs

*[Plans that do not offer mail-order services, replace the information in this section with the following sentence: Our plan does **not** offer mail-order services.]*

*[Include the following information only if your mail-order service is limited to a subset of all formulary drugs, adapting terminology as needed: For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition.] [Insert if plan marks mail-order drugs in formulary: Drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List.] [Insert if plan marks non-mail-order drugs in formulary: Drugs **not** available through our plan's mail-order service are marked with [plans should indicate how these drugs are marked] in our Drug List.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Our plan's mail-order service *[insert as appropriate: allows **or** requires]* you to order *[insert as appropriate: at least a <number of days>-day supply of the drug and no more than a <number of days>-day supply **or** up to a <number of days>-day supply **or** a <number of days>-day supply]*. A <number of days>-day supply has the same copay as a one-month supply.

## Filling prescriptions by mail

To get *[insert if applicable: order forms and]* information about filling your prescriptions by mail, *[insert instructions]*.

Usually, a mail-order prescription arrives within <number of days> days. *[Insert plan's process for members to get a prescription if the mail-order is delayed.]*

## Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

### 1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

*[Plans should include the appropriate information below from the following options, based on (1) whether the plan will automatically process new prescriptions consistent with the policy described in the December 12, 2013, CMS memorandum entitled "Clarification to the 2014 Policy on Automatic Delivery of Prescriptions," and 2016 Final Call Letter and (2) whether the plan offers an optional automatic refill program consistent with the policy described in the 2020 Final Call Letter. Plan sponsors who provide automatic delivery through retail or other non-mail means have the option to either add or replace the word "ship" with "deliver" as appropriate.]*

*[For **new prescriptions** received directly from health care providers, insert one of the following two options.]*

*[Plan sponsors that **do not** automatically process new prescriptions from provider offices, insert the following:]*

### 2. New prescriptions the pharmacy gets from your provider's office

After the pharmacy gets a prescription from a health care provider, it contacts you to find out if you want the medication filled immediately or at a later time.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allows you to stop or delay the order before *[plans with cost sharing for drugs, insert: you are billed and]* it is shipped.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

*[Plan sponsors that **do** automatically process new prescriptions from provider offices, insert the following:]*

## 2. New prescriptions the pharmacy gets from your provider's office

The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by *[insert instructions]*.

*[Plans with no cost sharing for drugs, delete the following sentence:]* If you get a prescription automatically by mail that you do not want, and you were not contacted to find out if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, contact us by *[insert instructions]*.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before *[plans with cost sharing for drugs, insert: you are billed and]* it is shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by *[insert instructions]*.

*[For refill prescriptions, insert one of the following two options.]*

*[Plans that **do not** offer a program that automatically processes refills, insert the following:]*

## 3. Refills on mail-order prescriptions



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

For refills, contact your pharmacy *[insert recommended number of days]* days before your current prescription will run out to make sure your next order is shipped to you in time.

*[Plans that do offer a program that automatically processes refills, insert the following:]*

### 3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program *[optional: called <name of auto refill program>]*. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy *[insert recommended number of days]* days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program *[optional: insert name of auto refill program instead of “our program”]* that automatically prepares mail-order refills, contact us by *[insert instructions]*.

*[All plans offering mail-order services, insert the following:]*

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. *[Insert instructions on how members should provide their communication preferences.]*

## A7. Getting a long-term supply of drugs

*[Plans that do not offer extended-day supplies, replace the information in this section with the following sentence: Our plan does not offer long-term supplies of drugs.]*

You can get a long-term 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. *[Insert if applicable: When you get a long-term supply of drugs, your copay may be lower.]*

*[Delete if the plan does not offer extended-day supplies through network pharmacies.]* Some network pharmacies allow you to get a long-term supply of maintenance drugs. A <number of days>-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call *[insert if applicable: your care coordinator or]* Member Services for more information.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



*[Delete if plan does not offer mail-order service.] [Insert as applicable: For certain kinds of drugs, you or You]* can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** *[insert reference, as applicable]* to learn about mail-order services.

## A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. *[Insert as applicable: We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.]*

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

*[Plans should insert a list of situations when they cover prescriptions out of the network (e.g., during a declared disaster) and any limits on their out-of-network policies (e.g., day supply limits, use of mail-order during extended out-of-area travel, authorization or plan notification).]*

In these cases, check with *[insert if applicable: your care coordinator or]* Member Services first to find out if there's a network pharmacy nearby.

## A9. Paying you back for a prescription

*[Plans may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]* If you must use an out-of-network pharmacy, you must generally pay the full cost *[plans with cost-sharing, insert: instead of a copay]* when you get your prescription. You can ask us to pay you back *[plans with cost-sharing, insert: for our share of the cost]*.

To learn more about this, refer to **Chapter 7** of your *Member Handbook*.

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## B. Our plan's Drug List

We have a *List of Covered Drugs*. We call it the "Drug List" for short.

We select the drugs on the Drug List with the help of a team of doctors and pharmacists. The Drug List also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's Drug List when you follow the rules we explain in this chapter.

*[Plans that offer indication-based formulary design must include: If we cover a drug only for some medical conditions, we clearly identify it on our Drug List and in Medicare Plan Finder along with the specific medical conditions covered.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under *[Insert name of state Medicaid program]*.

*[Insert either of the two sentences: “Our Drug List includes brand name drugs and generic drugs.” OR “Our Drug List includes brand name drugs, generic drugs, and biosimilars.”]*

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

Generic drugs have the same active ingredients as brand name drugs. *[Insert if applicable: Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars.]* Generally, generic drugs *[Insert if applicable: and biosimilars]* work just as well as brand-name drugs *[Insert if applicable: or biological products]* and usually cost less. There are generic drug substitutes *[Insert if applicable: or biosimilar alternatives]* available for many brand name drugs *[Insert if applicable: and some biological products]*. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

## B2. How to find a drug on our Drug List

To find out if a drug you take is on our Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit our plan’s website at <web address>. The Drug List on our website is always the most current one.
- Call *[insert if applicable: your care coordinator or]* Member Services to find out if a drug is on our Drug List or to ask for a copy of the list.

*[Plans may insert additional ways to find out if a drug is on the Drug List.]*

## B3. Drugs not on our Drug List

We don’t cover all prescription drugs. Some drugs are not on our Drug List because the law doesn’t allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List.

*[Plans should remove or modify language regarding benefit exclusions when the benefits are covered by the plan under the Medicaid program.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 10

Our plan does not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and *[insert name of state-specific Medicaid program]* drugs) cannot pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the Food and Drug Administration (FDA) or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or *[Insert name of Medicaid program]* cannot cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Outpatient drugs made by a company that says you must have tests or services done only by them

#### **B4. Drug List** *[Plans that do not have cost sharing in any tier may omit: cost sharing] tiers*

Every drug on our Drug List is in one of <number of tiers> *[Plans that do not have cost sharing in any tier may omit: cost-sharing] tiers*. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter (OTC) drugs). *[Plans that do not have cost sharing in any tier may omit the following sentence: In general, the higher the cost-sharing tier, the higher your cost for the drug.]*

*[Plans must briefly describe each tier (e.g., Cost-sharing Tier 1 includes generic drugs, or for plans with no cost sharing in any tier, Tier 1 includes generic drugs). Plans must ensure the tier label or description of the types of drugs on each tier is consistent with guidance regarding*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*generic tier labels in the 2016 Final Call Letter. Indicate which is the lowest tier and which is the highest tier.]*

To find out which *[Plans that do not have cost sharing in any tier may omit: cost-sharing]* tier your drug is in, look for the drug on our Drug List.

**Chapter 6** of your *Member Handbook* tells the amount you pay for drugs in each *[Plans that do not have cost sharing in any tier may omit: cost sharing]* tier.

## C. Limits on some drugs

For certain prescription drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

**If there is a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug.** For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, ask us to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

*[Plans should include only the forms of utilization management the plan uses. Plans delete any they don't use and renumber the list accordingly.]*

### 1. Limiting use of a brand name drug when a generic version is available

Generally, a generic drug works the same as a brand name drug and usually costs less. *[Insert as applicable: In most cases, if or If]* there is a generic version of a brand name drug available, our network pharmacies give you the generic version.

- We usually do not pay for the brand name drug when there is an available generic version.
- However, if your provider *[insert as applicable: told us the medical reason that the generic drug won't work for you or wrote "No substitutions" on your prescription for a brand name drug or told us the medical reason that the generic drug or other covered drugs that treat the same condition will work for you]*, then we cover the brand name drug.
- *[Plans that offer all drugs at \$0 cost-sharing, delete the following sentence:]* Your copay may be greater for the brand name drug than for the generic drug.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 12

## 2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from our plan before you fill your prescription. If you don't get approval, we may not cover the drug.

## 3. Trying a different drug first

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A does **not** work for you, then we cover Drug B. This is called step therapy.

## 4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services or check our website at <web address>. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to Chapter 9 of the *Member Handbook*.

---

## D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our Drug List. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above [\[insert reference, as applicable\]](#), some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

### D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our Drug List or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**To get a temporary supply of a drug, you must meet the two rules below:**

1. The drug you've been taking:
  - Is no longer on our Drug List **or**
  - Was never on our Drug List **or**
  - Is now limited in some way.
2. You must be in one of these situations:
  - *[Plans omit this scenario if the plan allows current members to ask for formulary exceptions in advance for the following year. Plans omit this scenario if the plan was not operating in the prior year.]* You were in our plan last year.
    - We cover a temporary supply of your drug **during the first *[insert time period (must be at least 90 days)]* days of the calendar year.**
    - This temporary supply is for up to *[insert supply limit (must be the number of days in plan's one-month supply)]* days.
    - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of *[insert supply limit (must be the number of days in plan's one-month supply)]* days of medication. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
  - You are new to our plan.
    - We cover a temporary supply of your drug **during the first *[insert time period (must be at least 90 days)]* days of your membership in our plan.**
    - This temporary supply is for up to *[insert supply limit (must be the number of days in plan's one-month supply)]* days.
    - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of *[insert supply limit (must be the number of days in plan's one-month supply)]* days of medication. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.



- You have been in our plan for more than *[insert time period (must be at least 90 days)]* days, live in a long-term care facility, and need a supply right away.
  - We cover one *[insert supply limit (must be at least a 31-day supply)]*-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - *[If applicable, plans insert their transition policy for current members with changes to their level of care.]*

## D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

### OR

- Ask for an exception.

You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our Drug List or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

*[Plans that do not allow current members to ask for an exception prior to the beginning of the following contract year may omit this paragraph:]*

## D3. Asking for an exception

If a drug you take will be taken off our Drug List or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you need help asking for an exception, contact Member Services *[insert if applicable: or your care coordinator]*.

---

## E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our Drug List during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year** unless:

- A new, cheaper drug comes on the market that works as well as a drug on our Drug List now, **or**
- We learn that a drug is not safe, **or**
- A drug is removed from the market.

To get more information on what happens when our Drug List changes, you can always:

- Check our current Drug List online at <web address> **or**
- Call Member Services at the number at the bottom of the page to check our current Drug List.

Some changes to our Drug List happen **immediately**. For example:

- *[Plans that otherwise meet all requirements and want the option to immediately replace brand name drugs with their generic equivalents must provide the following advance general notice of changes: **A new generic drug becomes available.** Sometimes, a new generic drug comes on the market that works as well as a brand name drug on our Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug stays the same *[insert if applicable, for example, if the plan's Drug List has differential cost-sharing for some generics: or will be lower.]**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 16



When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we send you information about the specific change we made once it happens.
- You or your provider can ask for an “exception” from these changes. We send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of your *Member Handbook* for more information on exceptions.]
- **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug’s manufacturer takes a drug off the market, we take it off our Drug List. If you are taking the drug, we tell you. *[Plans include information advising members what to do after they are notified (e.g., contact the prescribing doctor, etc.).]*

**We may make other changes that affect the drugs you take.** We tell you in advance about these other changes to our Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- *[Plans that want the option to immediately substitute a new generic drug, insert: We add a generic drug that is not new to the market and*
  - Replace a brand name drug currently on our Drug List **or**
  - Change the coverage rules or limits for the brand name drug.]
- *[Plans that are not making immediate generic substitutions insert: We add a generic drug and*
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.]

When these changes happen, we:

- Tell you at least 30 days before we make the change to our Drug List **or**
- Let you know and give you a *[insert supply limit (must be at least the number of days in the plan’s one-month supply)]*-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on our Drug List you can take instead **or**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- If you should ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

**We may make changes to drugs you take that do not affect you now.** For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally do not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking *[insert if applicable: , increase what you pay for the drug,]* or limit its use, then the change does not affect your use of the drug *[insert if applicable: or what you pay for the drug]* for the rest of the year.

---

## F. Drug coverage in special cases

### F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you are admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your prescription drugs during your stay. You will not pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

*[Plans with no cost-sharing, delete this paragraph:]* To learn more about drug coverage and what you pay, refer to **Chapter 6** of your *Member Handbook*.

### F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has their own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not or if you need more information, contact Member Services.

### F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug that your hospice does not cover because it is not related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of your *Member Handbook* for more information about the hospice benefit.

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## G. Programs on drug safety and managing drugs

### G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- May not be needed because you take another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we work with your provider to correct the problem.

### G2. Programs to help you manage your drugs

*[If plan has more than one medication therapy management program update language to reflect this.]* Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

Then, they will give you:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you do not want to be in the program, let us know, and we will take you out of it.

If you have questions about these programs, contact Member Services [\[insert if applicable: or your care coordinator\]](#).

### G3. Drug management program for safe use of opioid medications

Our plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid [\[insert if applicable: or benzodiazepine\]](#) medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications from [\[insert: a certain pharmacy or certain pharmacies\]](#) and/or from [\[insert: a certain doctor or certain doctors\]](#)
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter explains the limitations we think should apply.

**You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know.** If we decide to limit your coverage for



these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization. To learn more about appeals and the Independent Review Organization, refer to **Chapter 9** of your *Member Handbook*.)

The DMP may not apply to you if you:

- Have certain medical conditions, such as cancer or sickle cell disease,
- Are getting hospice, palliative, or end-of-life care, **or**
- Live in a long-term care facility.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 6: What you pay for your Medicare and *[Insert name of Medicaid program]* Medicaid prescription drugs

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### Introduction

This chapter tells what you pay for your outpatient prescription drugs. By “drugs,” we mean:

- Medicare Part D prescription drugs, **and**
- Drugs and items covered under Medicaid, **and**
- Drugs and items covered by our plan as additional benefits.

Because you are eligible for *[insert state-specific name of Medicaid program]*, you get “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs. *[Plans who have \$0 cost sharing for all Medicare Part D drugs should remove the remaining language in this paragraph.]* We *[insert as appropriate: have included or sent you]* a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

**Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

To learn more about prescription drugs, you can look in these places:

- Our *List of Covered Drugs*.
  - We call this the “Drug List.” It tells you:
    - Which drugs we pay for
    - Which of the <number of tiers> *[Plans that do not have cost sharing in any tier may omit: cost-sharing]* tiers each drug is in
    - If there are any limits on the drugs



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at <web address>.
- **Chapter 5** of your *Member Handbook*.
  - It tells how to get your outpatient prescription drugs through our plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.
- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of your *Member Handbook* more information about network pharmacies.

*[Plans with no cost-sharing for all outpatient drugs, delete Sections D, E, F, and G and change section H to section D.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 2

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## A. The *Explanation of Benefits* (EOB)

*[Plans with a single payment stage (i.e., no cost-sharing differences between the Initial Coverage Stage and the Catastrophic Coverage Stage), modify this section as necessary.]*

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount we pay.

When you get prescription drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB is not a bill. The EOB has more information about the drugs you take *[insert, as applicable: such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options]*. The EOB includes:

- **Information for the month**. The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **Year-to-date information**. This is your total drug costs and total payments made since January 1.
- **Drug price information**. This is the total price of the drug and any percentage change in the drug price since the first fill.
- **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count towards your total out-of-pocket costs.
- *[Insert only if the plan pays for OTC drugs as part of its administrative costs under Medicare Part D, rather than as a Medicaid benefit: We also pay for some over-the-counter drugs. You do not have to pay anything for these drugs.]*
- To find out which drugs our plan covers, refer to our Drug List. *[Insert if applicable: In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under <insert state-specific name of Medicaid program>. These drugs are included in the Drug List.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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## B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

### 1. Use your plan ID card.

Show your plan ID card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

### 2. Make sure we have the information we need.

Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for *[insert if plan has cost-sharing: our share of the cost of]* the drug.

Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

For more information about asking us to pay you back for *[insert if plan has cost-sharing: our share of the cost of]* a drug, refer to **Chapter 7** of your *Member Handbook*.

### 3. Send us information about payments others have made 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, the Indian Health Service, and most charities count toward your out-of-pocket costs. *[Plans should delete the rest of this paragraph if they cover all Medicare Part D drugs at \$0 cost-sharing:]* This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

### 4. Check the EOBs we send you.

- When you get an EOB in the mail, make sure it is complete and correct.

**Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

For more information, you can call <plan name> Member Services or read the <plan name> *Member Handbook*. *[Plans must include information about how to access the Member Handbook on the plan's website.]*

### What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this *Explanation of Benefits*, please call us at <plan name> Member Services. *[If applicable: You can also find answers to many questions on our website: <MMP web address>.]*

### What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at <plan name> Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- *[Plans may also insert additional State-based resources for reporting fraud.]*

If you think something is wrong or missing, or if you have any questions, call Member Services. *[Plans that allow members to manage this information online may describe that option here.]*

Keep these EOBs. They are an important record of your drug expenses.

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### C. *[Plans with two payment stages, insert: Drug Payment Stages for Medicare Part D drugs] [Plans with one payment stage, insert: You pay nothing for a one-month [insert if applicable: or long-term] supply of drugs]*

*[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following sentence: With our plan, you pay nothing for covered drugs as long as you follow our rules.]*

*[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), include the following paragraph and table.]*

There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Stage 1: Initial Coverage Stage                                                                                                                                                                             | Stage 2: Catastrophic Coverage Stage                                                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay.</p> <p>You begin in this stage when you fill your first prescription of the year.</p> | <p>During this stage, we pay all of the costs of your drugs through &lt;end date&gt;.</p> <p>You begin this stage when you have paid a certain amount of out-of-pocket costs.</p> |

*[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following information up to Section D.]*

### **C1. Our** *[Plans that do not have cost sharing in any tier may omit: **cost-sharing** tiers]*

*[Plans must provide an explanation of tiers; refer to the examples below. Plans must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter.]*

*[Plans that have cost sharing in any tier include: Cost-sharing tiers are groups of drugs with the same copay. Every drug on our Drug List is in one of <number of tiers> cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our Drug List.*

*If a plan has no cost sharing for one or more tiers of drugs, the plan should modify the cost sharing information accordingly. Include examples such as the following:*

- Tier 1 drugs have the lowest copay. They may be generic drugs or non-Medicare drugs that are covered by Medicaid. The copay is from <amount> to <amount>, depending on your income.
- Tier 2 drugs have a medium copay. They are brand name drugs. The copay is from <amount> to <amount>, depending on your income.
- Tier 3 drugs have the highest copay. The copay is <amount>.]

*[Plans that do not have cost sharing in any tier include: Tiers are groups of drugs on our plan's Drug List. Every drug on our Drug List is in one of <number of tiers> tiers. You have no copays for prescription and OTC drugs on our Drug List. To find the tiers for your drugs, refer to our Drug List.*

*Include examples such as the following:*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Tier 1 drugs are generic drugs.
- Tier 2 drugs are brand name drugs.]

## C2. Your pharmacy choices

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

- a network pharmacy, **or**
- an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of your *Member Handbook* to find out when we do that. Refer to **Chapter 9** of the *Member Handbook* to learn about how to file an appeal if you are told a drug will not be covered.

To learn more about these pharmacy choices, refer to **Chapter 5** of your *Member Handbook* and our *Provider and Pharmacy Directory*.

## C3. Getting a long-term supply of a drug

*[Plans that do not offer extended supplies, delete the following two paragraphs:]*

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is *[insert if applicable: up to]* a <number of days>-day supply. *[Plans with cost-sharing, insert: It costs you the same as a one-month supply.] [Plans with no cost-sharing, insert: There is no cost to you for a long-term supply.]*

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Member Handbook* or our *Provider and Pharmacy Directory*.

## C4. What you pay

*[Plans that have copays on at least one tier must include the following language:]* You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Member Services to find out how much your copay is for any covered drug.

**Your share of the cost when you get a one-month *[insert if applicable: or long-term]* supply of a covered prescription drug from:**

*[Plans may delete columns and modify the table as necessary to reflect the plan’s prescription drug coverage. Include all possible copay amounts (not just the high/low ranges) – i.e., all three possible copay amounts for a tier in which LIS cost sharing applies – in the chart, as well as a statement that the copays for prescription drugs may vary based on the level of Extra Help the member gets (if the plan charges copays for any of its Medicare Part D drugs). Modify the chart as necessary to include \$0 copays for non-Medicare covered drugs. Plans must ensure the tier*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter.]*

*[Plans should add or remove tiers as necessary. Plans should remove references to “cost sharing” to describe tiers if they do not have cost sharing in any tier. If mail-order is not available for certain tiers, plans should insert the following text in the cost-sharing cell: Mail-order is not available for drugs in [insert tier].]*

|                                                                                           | <b>A network pharmacy</b>                          | <b>Our plan’s mail-order service</b>               | <b>A network long-term care pharmacy</b> | <b>An out-of-network pharmacy</b>                                                                                                                |
|-------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                           | A one-month or up to a <number of days>-day supply | A one-month or up to a <number of days>-day supply | Up to a <number of days>-day supply      | Up to a <number of days>-day supply. Coverage is limited to certain cases. Refer to <b>Chapter 5</b> of your <i>Member Handbook</i> for details. |
| <b>Cost-sharing Tier 1</b><br><br>( <i>[Insert description; e.g., “generic drugs.”]</i> ) | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 2</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 3</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 4</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |

For information about which pharmacies can give you long-term supplies, refer to our plan’s *Provider and Pharmacy Directory*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## D. Stage 1: The Initial Coverage Stage [*Plans with one coverage stage should delete this section*]

During the Initial Coverage Stage, we pay a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on the cost-sharing tier the drug is in and where you get it.

*[Plans must provide an explanation of tiers; refer to the examples below. Plans have flexibility to describe their tier model but must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter. Plans may also edit or delete language regarding Medicaid based on Medicaid coverage.]*

*[Plans that have cost sharing in any tier include:* Cost-sharing tiers are groups of drugs with the same copay. Every drug on our plan's Drug List is in one of <number of tiers> cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our Drug List.

- Tier 1 drugs have the lowest copay. They may be generic drugs or non-Medicare drugs that *[Insert state-specific name of Medicaid program]* covers. The copay is from <amount> to <amount>, depending on your income.
- Tier 2 drugs have a medium copay. They are brand name drugs. The copay is from <amount> to <amount>, depending on your income.
- Tier 3 drugs have the highest copay. The copay is <amount>.]

*[Plans that do not have cost sharing in any tier include:* Tiers are groups of drugs on our plan's Drug List. Every drug on our Drug List is in one of <number of tiers> tiers. You have no copay for prescription and OTC drugs on our Drug List. To find the tiers for your drugs, refer to our Drug List.

*Include examples such as the following:*

- Tier 1 drugs are generic drugs.
- Tier 2 drugs are brand name drugs.]

### D1. Your pharmacy choices

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

- A network pharmacy **or**
- An out-of-network pharmacy.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 10

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of your *Member Handbook* to find out when we do that.

To learn more about these choices, refer to **Chapter 5** of your *Member Handbook* and to our *Provider and Pharmacy Directory*.

## D2. Getting a long-term supply of a drug

*[Plans that do not offer extended supplies, delete the following two paragraphs:]*

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is *[insert if applicable: up to]* a <number of days>-day supply. *[Plans with cost-sharing, insert: It costs you the same as a one-month supply.] [Plans with no cost-sharing, insert: There is no cost to you for a long-term supply.]*

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Member Handbook* or our plan’s *Provider and Pharmacy Directory*.

## D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Member Services to find out how much your copay is for any covered drug.

**Your share of the cost when you get a one-month *[insert if applicable: or long-term]* supply of a covered prescription drug from:**

*[Plans may delete columns and modify the table as necessary to reflect the plan’s prescription drug coverage. Include all possible copay amounts (not just the high/low ranges) – i.e., all three possible copay amounts for a tier in which LIS cost sharing applies – in the chart, as well as a statement that the copays for prescription drugs may vary based on the level of Extra Help the member gets. Plans must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter.]*

*[Plans should add or remove tiers as necessary. Plans should remove references to “cost sharing” to describe tiers if they do not have cost sharing in any tier. If mail-order is not available for certain tiers, plans should insert the following text in the cost-sharing cell: Mail-order is not available for drugs in *[insert tier]*.]*





|                                                                                           | <b>A network pharmacy</b>                          | <b>Our plan's mail-order service</b>               | <b>A network long-term care pharmacy</b> | <b>An out-of-network pharmacy</b>                                                                                                                |
|-------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                           | A one-month or up to a <number of days>-day supply | A one-month or up to a <number of days>-day supply | Up to a <number of days>-day supply      | Up to a <number of days>-day supply. Coverage is limited to certain cases. Refer to <b>Chapter 5</b> of your <i>Member Handbook</i> for details. |
| <b>Cost-sharing Tier 1</b><br><br>( <i>[Insert description; e.g., "generic drugs."]</i> ) | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 2</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 3</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 4</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |

For information about which pharmacies can give you long-term supplies, refer to our *Provider and Pharmacy Directory*.

#### D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



Your Explanation of Benefits (EOB) helps you keep track of how much you have paid for your drugs during the year. We let you know if you reach the *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]* limit. Many people do not reach it in a year.

---

## **E. Stage 2: The Catastrophic Coverage Stage** *[Plans with one coverage stage should delete this section]*

When you reach the out-of-pocket limit of *[\$<TrOOP amount>]* for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, our plan pays all of the costs for your Medicare drugs.

---

## **F. Your drug costs if your doctor prescribes less than a full month's supply** *[Plans with no Medicare Part D drug cost-sharing should delete this section]*

*[Insert as appropriate: Usually or In some cases]*, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects).
- If your doctor agrees, you do not pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. 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.

- *[Plans may revise the information in this paragraph to reflect the appropriate number of days for their one-month supplies as well as the cost-sharing amount in the example.]* Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment is less than \$.05 per day multiplied by 7 days, for a total payment less than \$0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 13

- Better plan when to refill your drugs,
- Coordinate refills with other drugs you take, **and**
- Take fewer trips to the pharmacy.

---

## G. Prescription cost-sharing assistance for persons with HIV/AIDS

*[Plans with no Medicare Part D drug cost-sharing delete this section]*

### G1. The AIDS Drug Assistance Program (ADAP)

The AIDS Drug Assistance Program (ADAP) helps eligible individuals living with HIV/AIDS access life-saving HIV medications. Outpatient Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the *[insert name of state-specific department]* for individuals enrolled in ADAP.

### G2. If you are not enrolled in ADAP

For information on eligibility criteria, covered drugs, or how to enroll in the program, call *[insert phone number]* or check the ADAP website at *[insert website address]*.

### G3. If you are enrolled in ADAP

ADAP can continue to provide ADAP clients with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. To be sure you continue getting this assistance, notify *[insert description of who to notify]* of any changes in your Medicare Part D plan name or policy number. If you need help finding the nearest ADAP enrollment site and/or enrollment worker, call *[insert phone number]* or check the website listed above.

---

## H. Vaccinations

*[Plans may revise this section as needed.]*

We cover Medicare Part D vaccines. There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

### H1. What you need to know before you get a vaccination

*[Plans may revise this section as needed.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 14

We recommend that you call Member Services if you plan to get a vaccination.

- We can tell you about how our plan covers your vaccination *[insert if the plan has cost-sharing: and explain your share of the cost]*.
- *[Insert if applicable: We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider work with us to ensure that you have no upfront costs for a Medicare Part D vaccine.]*

*[Plans that do not charge any Medicare Part D vaccine copays may delete the following section.]*

## H2. What you pay for a vaccination covered by Medicare Part D

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. *[Insert if applicable: You may have to pay a copay for Medicare Part D vaccines.]*

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
  - You pay *[insert as applicable: nothing or a copay]* for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
  - You pay *[insert as applicable: nothing or a copay]* to the doctor for the vaccine.
  - Our plan pays for the cost of giving you the shot.
  - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay *[insert as applicable: nothing or a copay]* for the vaccine.
3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
  - You pay *[insert as applicable: nothing or a copay]* for the vaccine.



- Our plan pays for the cost of giving you the shot.

*[Insert any additional information about your coverage of vaccinations.]*



## Chapter 7: Asking us to pay *[plans with cost sharing, insert: our share of]* a bill you got for covered services or drugs

---

### Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans with an arrangement with the State may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits. Plans may not revise the chapter or section headings except as indicated.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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## A. Asking us to pay for your services or drugs

*[Plans with cost sharing delete the next sentence.]* You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We do not allow <plan name> providers to bill you for these services *[insert as applicable: or drugs]*. We pay our providers directly, and we protect you from any charges.

**If you get a bill for *[plans with cost sharing insert: the full cost of]* health care or drugs, do not pay the bill and send the bill to us.** To send us a bill, refer to *[plans may insert reference, as applicable]*.

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid *[plans with cost sharing, insert: more than your share of the cost; plans with no cost sharing, insert: the bill]*, it is your right to be paid back.
  - If you paid for services covered by Medicare, we will pay you back.
  - If you paid for services covered by *[insert name of state-specific Medicaid program]* we can't pay you back, but the provider will. Member services or *[insert the term for your care coordinator]* can help you contact the provider's office. Refer to the bottom of the page for the member services phone number.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services *[insert if appropriate: or your care coordinator]* if you have any questions. If *[plans with cost sharing insert: you do not know what you should have paid, or if]* you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

### 1. When you get emergency or urgently needed health care from an out-of-network provider

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back *[plans with cost sharing insert: for our share of the cost]*. Send us the bill and proof of any payment you made.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - If the provider should be paid, we will pay the provider directly.
  - If you already paid *[plans with cost sharing insert: more than your share of the cost]* for the Medicare service, we will *[plans with cost sharing insert: figure out how much you owed and]* pay you back *[plans with cost sharing insert: for our share of the cost]*.

## 2. When a network provider sends you a bill

Network providers must always bill us, it's important to show your plan ID card when you get any services or prescriptions. But sometimes they make mistakes, and ask you to pay for your services or more than your share of the costs. **Call Member Services** *[insert if appropriate: or your care coordinator]* at the number at the bottom of this page **if you get any bills.**

- *[Plans with no cost sharing, insert: Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.]*
- *[Plans with cost sharing, insert: As a plan member, you only pay the copay when you get services we cover. We don't allow providers to bill you more than this amount. This is true even if we pay the provider less than the provider charged for a service. Even if we decide not to pay for some charges, you still do not pay them.]*
- Whenever you get a bill from a network provider *[plans with cost sharing insert: that you think is more than you should pay]*, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, *[plans with cost sharing insert: but you feel that you paid too much,]* send us the bill and proof of any payment you made. We will pay you back *[insert as appropriate: for your covered services or for the difference between the amount you paid and the amount you owed under our plan]*.

## 3. If you are retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Send us the bill and proof of any payment you made.

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, will we cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back [\[plans with cost sharing insert: for our share of the cost\]](#).
- Refer to **Chapter 5** of your *Member Handbook* to learn more about out-of-network pharmacies.

#### 5. When you pay the full [\[insert if only applicable to Medicare Part D: Medicare Part D\]](#) prescription cost because you don't have your plan ID card with you

If you don't have your plan ID card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your plan ID card.
- Send us a copy of your receipt when you ask us to pay you back [\[plans with cost sharing insert: for our share of the cost\]](#).

#### 6. When you pay the full [\[insert if only applicable to Medicare Part D: Medicare Part D\]](#) prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Member Handbook*).
  - If you and your doctor or other prescriber think you need the drug right away, (within 72 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your *Member Handbook*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for [\[plans with cost sharing insert: our share of the cost of\]](#) the drug.





When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide the service or drug should be covered, we pay for *[insert if the plan has cost sharing: our share of the cost of]* it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your *Member Handbook*.

---

## B. Sending us a request for payment

*[Plans may edit this section to include a second address if they use different addresses for processing health care and drug claims.]*

*[Plans may edit this section as necessary to describe their claims process.]*

Send us your bill and proof of any payment you made for Medicare services *[Insert if allowed: or call us]*. Proof of payment can be a copy of the check you wrote or a receipt from the provider.

**It’s a good idea to make a copy of your bill and receipts for your records.** *[Plans with care coordinators who can assist, insert: You can ask your care coordinator for help.] [Insert if applicable: You must send your information to us within [insert timeframe] of the date you received the service, item, or drug.]*

*[If the plan has a specific form for requesting payment, insert the following language: To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.*

- You aren’t required to use the form, but it helps us process the information faster.
- You can get the form on our website (<web address>), or you can call Member Services and ask for the form.]

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

*[Insert address.]*

*[If the plan allows members to submit oral payment requests, insert the following language:*

*You may also call us to ask payment.] [Plans include all applicable numbers and days and hours of operation.]*

*[Insert if applicable: You must submit your claim to us within <number of days> days of the date you got the service, item, or drug.]*

---

## C. Coverage decisions



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug.** We also decide the amount of money, if any, you must pay.

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay *[plans with cost sharing insert: our share of the cost]* for it. If you already paid for the service or drug, we will mail you a check for *[insert as applicable: what you paid or our share of the cost]*. If you haven't paid, we will pay the provider directly.

**Chapter 3** of your *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of your *Member Handbook* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for *[plans with cost sharing insert: our share of the cost of]* the service or drug, we will send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9 *[insert reference, as applicable]*.

---

## D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called “making an appeal.” You can also make an appeal if you don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of your *Member Handbook*: *[plans may insert reference, as applicable]*.

- To make an appeal about getting paid back for a health care service, refer to **Section F** *[insert reference, as applicable]*.
- To make an appeal about getting paid back for a drug, refer to **Section G** *[insert reference, as applicable]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 8: Your rights and responsibilities

---

### Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Note: Plans may add to or revise this chapter as needed to reflect NCQA required language or language required by state Medicaid program.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Your right to get services and information in a way that meets your needs

*[Plans may edit the section heading and content to reflect the types of alternate format materials available to plan members. Plans may not edit references to language except as noted below.]*

*[Plans must insert a translation of this section in all languages that meet the language threshold.]*

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call *[insert if applicable: your care coordinator or]* Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials *[insert if required to provide materials in any non-English languages: in languages other than English and]* in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call or write to *[Insert Plan name, address, and phone number]*. *[Plans specifically state which languages are offered. Plans also simply describe:*
  - *how they request a member's preferred language other than English and/or alternate format,*
  - *how they keep the member's information as a standing request for future mailings and communications so the member doesn't need to make a separate request each time, and*
  - *how a member can change a standing request for preferred language and/or format.]*

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- *[Plans should insert information about filing a complaint with Medicaid. Also, include any other state-required offices.]*
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## B. Our responsibility for your timely access to covered services and drugs

*[Plans may edit this section to add specific requirements for minimum access to care and remedies.]*

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Member Handbook*.
  - Call *[insert if applicable: your care coordinator or]* Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- *[Plans may edit this sentence to add other types of providers that members may use without a referral.]* Women have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that is not your PCP. *[If applicable, replace the previous sentences with: We do not require you to get referrals. or We do not require you to use network providers.]*
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Member Handbook*.
- *[Plans should include any additional state requirements regarding covered services or drugs here.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Chapter 9** of your *Member Handbook* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

## C. Our responsibility to protect your personal health information (PHI)

We protect your personal health information (PHI) as required by federal and state laws.

Your PHI includes information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights ~~to~~ when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

### C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws. *[Plans may insert similar information, as appropriate, about sharing medical records with Medicaid]*

**Commented [AA1]:** Add bullet underneath here:  
Healthcare Operations per HIPAA

### C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. *[Insert if applicable: We may charge you a fee for making a copy of your medical records.]*
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you have questions or concerns about the privacy of your PHI, call Member Services.

*[Plans may insert custom privacy practices.]*

---

## D. Our responsibility to give you information

*[Plans may edit the section to reflect the types of alternate format materials available to plan members and/or languages primarily spoken in the plan's service area.]*

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call us at <phone number>. This is a free service to you. *[Plans must insert information about the availability of written materials in languages other than English, stating specifically which languages are offered.]* We can also give you information in large print, braille, or audio. *[If applicable, plans insert information about the availability of written materials in other formats.]*

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of your *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Member Handbook*) covered by our plan
  - limits to your coverage and drugs



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Member Handbook*), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

---

## E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of your *Member Handbook*.

---

## F. Your right to leave our plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another MA plan.
- Refer to **Chapter 10** of your *Member Handbook*:
  - For more information about when you can join a new MA or prescription drug benefit plan.
  - For information about how you will get your [\[Insert name of Medicaid program\]](#) benefits if you leave our plan.

---

## G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

### G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Member Handbook* tells how to ask us for a coverage decision.

## **G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself**

*[Note: Plans that would like to provide members with state-specific information about advance directives may do so. Include contact information for the appropriate state agency.]*

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you.**
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do **not** want.

The legal document that you use to give your directions is called an “advance directive.” There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You are not required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. *[Insert if applicable: You can also contact Member Services to ask for the form.]*
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- *[Insert any additional state-specific requirements as directed by the state.]*

Call Member Services for more information.

### G3. What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with *[plans insert the name and contact information of the applicable state-specific agency]*.

---

## H. Your right to make complaints and ask us to reconsider our decisions

**Chapter 9** of your *Member Handbook* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

### H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it is **not** about discrimination for reasons listed in **Chapter 11** of your *Member Handbook* – or you want more information about your rights, you can call:

- Member Services at *<insert phone and TTY numbers>*.
- The *[insert name of state-specific SHIP]* program at *[insert phone number]*. For more details about *[insert name of state-specific SHIP]*, refer to Chapter 2 *[insert reference, as applicable]*.
- *[Insert this section if applicable: The Ombudsman Program at <phone number>. For more details about this program, refer to Chapter 2 of your Member Handbook.]*

Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at [www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf](http://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf).)

*[If applicable, plans should insert additional contact information, such as for the state Medicaid agency.]*

---

## I. Your responsibilities as a plan member

*[Plans may modify this section to include additional member responsibilities. Plans may add information about estate recovery and other requirements mandated by the state.]*

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your *Member Handbook*. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your plan ID card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- *[Plans should edit the bullets below as needed to reflect the costs applicable to their members.]* **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most *<plan name>* members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.
  - *[Delete this bullet if the plan does not have cost sharing:]* For some of your *[insert if the plan has cost sharing for long-term services and supports: long-term services and supports [or drugs]]* covered by the plan, you must pay your share of the cost when you get the *[insert if the plan has cost sharing for services: service [or drug]]*. This will be a *[insert as appropriate: [copayment/copay] (a fixed amount) or coinsurance (a percentage of the total cost)]*. *[Insert if the plan has cost sharing for long-term services and supports: Chapter 4 [plans may insert reference, as applicable] tells what you must pay for your long-term services and supports.] Chapter 6 [plans may insert reference, as applicable] tells what you must pay for your drugs.*

Commented [AA2]: The ability to edit the first bullet



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (Note: If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to Chapter 9 [plans may insert reference, as applicable] to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call [insert if applicable: your care coordinator or] Member Services.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Member Handbook* tells about our service area.
  - We can help you find out if you're moving outside our service area. [Plans that do not offer plans outside the service area may delete the following sentence:] During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and [Insert state-specific name of Medicaid program] your new address when you move. Refer to **Chapter 2** of your *Member Handbook* for phone numbers for Medicare and [Insert name of state-specific Medicaid program].
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Call [insert if applicable: your care coordinator or] Member Services for help if you have questions or concerns.**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

*[Plans that integrate the description of Medicare and Medicaid processes must revise the sections of this chapter as needed to clearly describe the appeals and grievance processes.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[In cases where members should contact a department other than Member Services (for example, a grievance and appeals unit), plans should revise the instructions to provide the appropriate contact information.]*

### Introduction

This chapter has information about your rights. Read this chapter to find out what to do if: [\[Add any additional language for state-specific Medicaid information\]](#)

**Commented [KG1]:** Should call out that this section can be used as a guide for how members can file an appeal(s).

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 1

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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## A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints**; also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

### A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” instead of “Independent Review Entity”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

---

## B. Where to get help

### B1. For more information and help

Sometimes it's confusing to start or follow the process for dealing with a problem. This can be especially true if you don't feel well or have limited energy. Other times, you may not have the information you need to take the next step.

**Help from the** *[Insert state-specific name of the SHIP program]*

You can call the *[insert state-specific name of the SHIP program]*. *[insert state-specific name of the SHIP program]* counselors can answer your questions and help you understand what to do about your problem. *[Insert state-specific name of the SHIP program]* is not connected with us or with any insurance company or health plan. *[Insert state-specific name of the SHIP program]* has trained counselors in every county, and services are free. The *[insert state-specific name of the SHIP program]* phone number is *[insert phone number]*.



---

**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)).

### Help and information from *[insert name of state-specific Medicaid program]*

*[Insert contact information for the state Medicaid agency. Insert similar sections for the QIO or ombudsman, as applicable.]*

---

## C. Understanding Medicare and *[insert name of state-specific Medicaid program]* complaints and appeals in our plan

You have Medicare and *[insert name of state-specific Medicaid program]*. Information in this chapter applies to **all** of your Medicare and *[insert name of state-specific Medicaid program]* benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and *[insert state-specific name of Medicaid program]* processes.

Sometimes Medicare and *[insert state-specific name of Medicaid program]* processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a *[insert state-specific name of Medicaid program]* benefit. **Section F4** explains these situations.

---

## D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The chart below helps you find the right section of this chapter for problems or complaints.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                                                                               |                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <b>Is your problem or concern about your benefits or coverage?</b><br><br>This includes problems about whether particular medical care or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs. |                                                                                                                                 |
| <b>Yes.</b><br>My problem is about<br>benefits or coverage.<br><br>Refer to <b>Section E</b> , "Coverage decisions<br>and appeals."                                                                                                                                           | <b>No.</b><br>My problem is not about<br>benefits or coverage.<br><br>Refer to <b>Section K</b> , "How to make a<br>complaint." |

## E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

### E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. We make a coverage decision whenever we decide what is covered for you and how much we pay. For example, your network doctor makes a favorable coverage decision for you whenever you get medical care from them or if they refer you to a medical specialist.

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or [\[insert state-specific name of Medicaid program\]](#). If you disagree with this coverage decision, you can make an appeal.

### E2. Appeals

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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 if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter *[insert reference, as applicable]*, you can ask for an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare medical service or item or Part B drugs, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

### E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- *[Insert name of SHIP program and contact information.]*
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

*[Insert any additional state-specific references for assistance with coverage decisions and appeals as applicable.]*

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the “Appointment of Representative” form. You can also get the form by visiting [www.cms.gov/Medicare/CMS-](http://www.cms.gov/Medicare/CMS-)



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

[Forms/CMS-Forms/downloads/cms1696.pdf](#) [plans may also insert: or on our website at <web address or link to form>]. You must give us a copy of the signed form.

#### E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, “Medical care” [insert reference, as applicable]
- **Section G**, “Medicare Part D prescription drugs” [insert reference, as applicable]
- **Section H**, “Asking us to cover a longer hospital stay” [insert reference, as applicable]
- **Section I**, “Asking us to continue covering certain medical services [insert reference, as applicable] (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page. [Plans may insert additional resources and contact information (e.g., SHIP, Ombudsman Program).]

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### F. Medical care

[Plans may update the heading and terms such as “medical care” throughout to account for Medicaid services such as behavioral health and long-term care services as directed by the state.]

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for [insert if plan has cost sharing: our share of the cost of] your care.

This section is about your benefits, medical care and services that are described in **Chapter 4** of your *Member Handbook*. We generally refer to “medical care coverage” or “medical care” in the rest of this section. The term “medical care” includes medical services and items as well as Medicare Part B prescription drugs which are drugs administered by your doctor or health care professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

#### F1. Using this section

This section explains what you can do in any of the five following situations:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

1. You think we cover medical care you need but are not getting.

**What you can do:** You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

**What you can do:** You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we will not pay.

**What you can do:** You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

**What you can do:** You can ask us to pay you back. Refer to **Section F5**. If care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Refer to **Section H** *[insert reference, as applicable]* or **Section I** *[insert reference, as applicable]* to find out more.

- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

## F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an "integrated organization determination."

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: *<phone number>* TTY: *<phone number>*.
- Faxing: *<phone number>*.
- Writing: *<address>*.

### Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer about a:

- Medical service or item within 14 calendar days after we get your request. *[Plan may adjust timeframe if state has more restrictive requirement as directed by the state.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Medicare Part B prescription drug within 72 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can't take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, Refer to **Section K** [\[insert reference, as applicable\]](#).

#### Fast coverage decision

The legal term for "fast coverage decision" is "**expedited determination.**"

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can't take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, Refer to **Section K** [\[insert reference, as applicable\]](#). We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You are asking for coverage for medical care you **did not get**. You can't ask for a fast coverage decision about payment for medical care you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



**We automatically give you a fast coverage decision if your doctor tells us your health requires it.** If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
- We automatically give you a fast coverage decision if your doctor asks for it.
- How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K** *[insert reference, as applicable]*.

**If we say No to part or all of your request**, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3** *[insert reference, as applicable]*).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- If the request is incomplete,
- If someone makes the request on your behalf but isn't legally authorized to do so, or
- If you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

### **F3. Making a Level 1 Appeal**

**To start an appeal**, you, your doctor, or your representative must contact us. Call us at *<phone number> [insert additional contact information, as applicable]*.

**Ask for a standard appeal or a fast appeal** in writing or by calling us at *<phone number>*.



**If you have questions**, please call *<plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>*. The call is free. **For more information**, visit *<web address>*.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, *[insert as applicable: you may need to name them as your representative to act on your behalf.]*
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) *[plans may also insert: or on our website at <web address or link to form>]*.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

The legal term for “fast appeal” is “**expedited reconsideration**.”

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.
- The process for a fast appeal is the same as for a fast coverage decision. To ask for a fast appeal, follow the instructions for asking for a fast coverage decision in **Section F2** *[insert reference, as applicable]*.
- If your doctor tells us that your health requires it, we will give you a fast appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.**

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.
  - If you do not appeal before these dates, then your service or medication will not be continued while you wait for your appeal decision.

**We consider your appeal and give you our answer.**

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

**There are deadlines for a fast appeal.**

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Independent Review Organization then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage if a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In <insert name of state> a Fair Hearing is called <insert description>.]*

- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request**, we send your appeal to the Independent Review Organization for a Level 2 Appeal.

**There are deadlines for a standard appeal.**

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If you think we should **not** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage if a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

as the time is up. In <insert name of state> a Fair Hearing is called <insert description>.]

If we say **Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights**:

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the Independent Review Organization for a Level 2 Appeal.
- If your problem is about coverage of a *[insert name of state-specific Medicaid program]* service or item, the letter tells you how to file a Level 2 Appeal yourself.

#### F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, *[insert name of state-specific Medicaid program]*, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that *[insert name of state-specific Medicaid program]* usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter *[insert reference, as applicable]*.
- If your problem is about a service or item that **both Medicare and** *[insert name of state-specific Medicaid program]* may cover, you automatically get a Level 2 Appeal with the Independent Review Organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** *[insert reference, as applicable]* for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the Independent Review Organization.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If your problem is about a service that usually covered only by [\[insert state-specific name of Medicaid program\]](#), your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

#### When your problem is about a service or item Medicare usually covers

The Independent Review Organization reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**," sometimes called the "IRE."

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the Independent Review Organization, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The Independent Review Organization must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- 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 getting your appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If your request is for a Medicare Part B prescription drug, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

The Independent Review Organization gives you their answer in writing and explains the reasons.

- **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 Independent Review Organization's decision for **standard requests or**
  - Provide the service **within 72 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- **If the Independent Review Organization says Yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:**
  - **Within 72 hours** after we get the Independent Review Organization's decision for **standard requests or**
  - **Within 24 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- **If the Independent Review Organization says No to part or all of your appeal**, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
- An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** *[insert reference, as applicable]* for more information about Level 3, 4, and 5 Appeals.

**When your problem is about a service or item Medicaid usually covers, or that is covered by both Medicare and *[insert name of state-specific Medicaid program]***

A Level 2 Appeal for services that *[insert name of state-specific Medicaid program]* usually covers is a Fair Hearing with the state. In *<insert name of state>* a Fair Hearing is called *<insert description>*. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

*[Plans should describe the process for Medicaid Level 2 Appeals, in which members must submit the Level 2 Appeal themselves.]*

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the Independent Review Organization or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **Independent Review Organization**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the Independent Review Organization explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** *[insert reference, as applicable]* for more information about your appeal rights after Level 2.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. *[Plans with cost sharing insert: The only amount you should be asked to pay is the copay for [insert service, item, and/or drug categories that require a copay].]*

*[Plans insert if the state DOES NOT allow members to be directly reimbursed for Medicaid benefits: We can't reimburse you directly for a Medicaid service or item. If you get a bill [plans with cost sharing insert: that is more than your copay] for Medicaid covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.]*

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to Chapter 7 of your Member Handbook.]

*[Plans insert if the state DOES allow members to be directly reimbursed for Medicaid benefits: If you get a bill [plans with cost sharing insert: that is more than your copay] for covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.]*

*For more information, refer to Chapter 7 of your Member Handbook. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.*

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.]

- If the service or item you paid for is covered and you followed all the rules, we will send *[insert: you or your provider] [insert: the payment or if the plan has cost sharing, our share of the cost]* for the service or item within 60 calendar days after we get your request. *[Insert, as applicable: Your provider will then send the payment to you.]*
- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3** *[insert reference, as applicable]*. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the Independent Review Organization. We will send you a letter if this happens.

- If the Independent Review Organization reverses our decision and says we should pay you, we must send the payment to you or to the provider 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 to you or to the health care provider within 60 calendar days.
- If the Independent Review Organization says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and *[insert name of Medicaid program]* usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information. *[Plans may edit as needed and/or provide additional instructions about the process for Level 2 payment appeals.]*

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## G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that *[insert name of state-specific Medicaid program]* may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section. Instead of saying "Medicare Part D drug" every time. *[Insert as applicable and adjust language as directed by the state: For drugs covered only by Medicaid follow the process in Section E on page <insert page number>.]*



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Member Handbook* for more information about a medically accepted indication.

## G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - Cover a Medicare Part D drug that is not on our plan's Drug List or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

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

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

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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 make an appeal. Use the chart below to help you.

| Which of these situations are you in?                                                                             |                                                                                                                                                              |                                                                               |                                                                             |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.     | You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need. | You want to ask us to pay you back for a drug you already got and paid for.   | We told you that we won't cover or pay for a drug in the way that you want. |
| <b>You can ask us to make an exception.</b> (This is a type of coverage decision.)                                | <b>You can ask us for a coverage decision.</b>                                                                                                               | <b>You can ask us to pay you back.</b> (This is a type of coverage decision.) | <b>You can make an appeal.</b> (This means you ask us to reconsider.)       |
| Start with <b>Section G2</b> , then refer to <b>Sections G3 and G4</b> <i>[insert reference, as applicable]</i> . | Refer to <b>Section G4</b> <i>[insert reference, as applicable]</i> .                                                                                        | Refer to <b>Section G4</b> <i>[insert reference, as applicable]</i> .         | Refer to <b>Section G5</b> <i>[insert reference, as applicable]</i> .       |

**G2. Medicare Part D exceptions**

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

**1. Covering a drug that is not on our Drug List**

- *[Plans without cost sharing delete]* If we agree to make an exception and cover a drug that is not on our Drug List, you pay the copay that applies *[insert as appropriate: to all of our drugs or drugs in [insert exceptions tier] or drugs in [insert exceptions tier] for brand name drugs or [insert exceptions tier] for generic drugs]*.
- You can't get an exception to the required copay amount for the drug.

## 2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Member Handbook* for more information).
  - Extra rules and restrictions for certain drugs include:
    - *[Omit if the plan does not use generic substitution]* Being required to use the generic version of a drug instead of the brand name drug.
    - *[Omit if the plan does not use prior authorization (PA)]* Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
    - *[Omit if the plan does not use step therapy]* Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
    - *[Omit if the plan does not use quantity limits]* Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
  - *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit this bullet.]* If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.
3. *[Plans with no cost sharing and plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions, omit this section.]* **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of *[insert number of tiers]* cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

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

- Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
  - *[Plans that have a formulary structure where all biological products are on one tier or that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.
  - *[Plans that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
  - *[Plans that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.
- *[If the plan designated one of its tiers as a “specialty tier” and exempts that tier from the exceptions process, include the following language: You can’t ask us to change the cost-sharing tier for any drug in [insert tier number and name of tier designated as the high-cost/unique drug tier].]*
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can’t take, you usually pay the lowest amount.

### G3. Important things to know about asking for an exception

#### Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for 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 often includes more than one drug for treating a specific condition. These are called “alternative” drugs. If an alternative drug is just as effective as the drug you ask for and wouldn’t cause more side effects or other health problems, we generally do **not** approve your exception request. *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit the next sentence.]* If you ask us for a tiering exception, we generally do **not** approve your exception request unless all 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 you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar 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 exception request, you can make an appeal. Refer to **Section G5** *[insert reference, as applicable]* for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

#### G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling <phone number>, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** *[insert reference, as applicable]* to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.
- *[Plans that allow members to submit coverage determination requests electronically (e.g., through a secure member portal) may include a brief description of that process.]*

#### If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

- You can get a fast coverage decision if:
- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K** [\[insert reference, as applicable\]](#).

#### Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization. Refer to **Section G6** [\[insert reference, as applicable\]](#) for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

### Deadlines for a standard coverage decision about 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 send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

## G5. Making a Level 1 Appeal

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

- Start your **standard** or **fast appeal** by calling <phone number>, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your claim.
- You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

had a serious illness or we gave you the wrong information about the deadline.  
Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal.  
You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

A fast appeal is also called an “**expedited redetermination.**”

- If you appeal a decision we made about a drug you didn’t get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** *[insert reference, as applicable]* for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1**

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
- We give you our answer sooner if your health requires it.
  - If we don’t give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** *[insert reference, as applicable]* for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

**Deadlines for a standard appeal at Level 1**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** [\[insert reference, as applicable\]](#) for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** [\[insert reference, as applicable\]](#) for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

## G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **Independent Review Organization** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

The formal name for the “Independent Review Organization” is the “**Independent Review Entity**,” sometimes called the “**IRE**.”

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the Independent Review Organization **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you include **instructions about how to make a Level 2 Appeal** with the Independent Review Organization. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the Independent Review Organization, we send the information we have about your appeal to the organization. This information is called your “case file.” **You have the right to a free copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

The Independent Review Organization reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** *[insert reference, as applicable]* for more information about the Independent Review Organization.

#### **Deadlines for a fast appeal at Level 2**

If your health requires it, ask the Independent Review Organization for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the Independent Review Organization's decision.

#### **Deadlines for a standard appeal at Level 2**

If you have a standard appeal at Level 2, the Independent Review Organization must give you an answer:

- **Within 7 calendar days** after they get your appeal for a drug you didn't get.
- **Within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the Independent Review Organization says **Yes** to part or all of your request:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We must provide the approved drug coverage **within 72 hours** after we get the Independent Review Organization's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the Independent Review Organization's decision.
  - If the Independent Review Organization says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the Independent Review Organization says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The Independent Review Organization sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the Independent Review Organization says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the Independent Review Organization sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Member Handbook*.

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

## H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Call Medicare at 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit [www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices).

## H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In *[insert name of state]*, the Quality Improvement Organization is *[insert state-specific QIO name]*. Call them at *[insert QIO toll-free phone number]*. Contact information is also in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**.

**Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date.**

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the Quality Improvement Organization’s decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, appeal to our plan directly instead. Refer to **Section G4** *[insert reference, as applicable]* for information about making an appeal to us.

**Ask for help if you need it.** If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the *[insert name of state SHIP including contact information]*.

**Ask for a fast review.** Act quickly and contact the Quality Improvement Organization to ask for a fast review of your hospital discharge.

The legal term for “**fast review**” is “**immediate review**” or “**expedited review**.”



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### What happens during fast review

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the “**Detailed Notice of Discharge.**” You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices).

Within one full day after getting all of the information it needs, the Quality Improvement Organization give you their answer to your appeal.

If the Quality Improvement Organizations says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Improvement Organization says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- 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 their answer to your appeal.
- You can make a Level 2 Appeal if the Quality Improvement Organization turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

### H3. Making a Level 2 Appeal



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at [\[insert QIO toll-free phone number\]](#).

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

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Quality Review Organization says **Yes** to your appeal:

- We must pay you back for [\[plans with cost sharing should include: our share of\]](#) hospital care costs since noon on the day after the date the Quality Improvement Organization turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Review Organization says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

#### H4. Making a Level 1 Alternate Appeal

The deadline for contacting the Quality Improvement Organization for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

The legal term for "fast review" or "fast appeal" is **"expedited appeal."**

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any [\[plans with cost sharing should include: share\]](#) of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of giving saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** [\[insert reference, as applicable\]](#) for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- Home health care services
- Skilled nursing care in a skilled nursing facility
- Rehabilitation care as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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.

### I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

### I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** *[insert reference, as applicable]* for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the *[insert state name of SHIP program and contact information]*.
- **Contact the Quality Improvement Organization.**
  - Refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal."** Ask the Quality Improvement Organization if it's medically appropriate for us to end coverage of your medical services.

#### Your deadline for contacting this organization

- 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 we sent you.
- If you miss the deadline for contacting the Quality Improvement Organization, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4** *[insert reference, as applicable]*.

The legal term for the written notice is "**Notice of Medicare Non-Coverage.**" To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or get a copy online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices).

#### What happens during a fast-track appeal



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is “**Detailed Explanation of Non-Coverage.**”

- Reviewers tell you their decision within one full day after getting all the information they need.

If the Independent Review Organization says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying *[plans with cost sharing should include: our share of]* the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

### **I3. Making a Level 2 Appeal**

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at *[insert QIO toll-free phone number]*.

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 continue care after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

#### **I4. Making a Level 1 Alternate Appeal**

As explained in **Section I2** [\[insert reference, as applicable\]](#), you must act quickly and contact the Quality Improvement Organization to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review.”

The legal term for “fast review” or “fast appeal” is “**expedited appeal**.”

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We agree to pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- If we say **No** to your fast appeal:
- Our coverage for these services ends on the date we told you.
- We will not pay any *[plans with cost sharing should include: share]* of the costs after this date.
- You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

**Commented [KG2]:** Formatting: these bullets should be sub bullets under "If we say No to your fast appeal:"

## 15. Making a Level 2 Alternate Appeal

During the Level 2 Appeal,

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** *[insert reference, as applicable]* for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## J. Taking your appeal beyond Level 2

### J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the Independent Review Organization for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we 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 service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 reviews your appeal and gives you an answer. The Council is part of the federal government.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

#### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. **There are no other appeal levels beyond the Federal District Court.**

**Commented [KG3]:** Formatting: suggest bolding this sentence

#### J2. Additional *[insert name of state-specific Medicaid program]* appeals

You also have other appeal rights if your appeal is about services or items that *[insert name of state-specific Medicaid program]* usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

*[Plans may, at the discretion of the state, insert a clear, brief description of the procedures, timing, and instructions about what members need to do if they want to file an additional appeal in the state.]*

#### J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

#### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

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## K. How to make a complaint

### K1. What kinds of problems should be complaints



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If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

**Commented [KG4]:** These added charts are very useful and "member friendly"

| Complaint                                                             | Example                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Quality of your medical care</b>                                   | <ul style="list-style-type: none"> <li>You are unhappy with the quality of care, such as the care you got in the hospital.</li> </ul>                                                                                                                                                                                                                                                                        |
| <b>Respecting your privacy</b>                                        | <ul style="list-style-type: none"> <li>You think that someone did not respect your right to privacy or shared confidential information about you.</li> </ul>                                                                                                                                                                                                                                                 |
| <b>Disrespect, poor customer service, or other negative behaviors</b> | <ul style="list-style-type: none"> <li>A health care provider or staff was rude or disrespectful to you.</li> <li>Our staff treated you poorly.</li> <li>You think you are being pushed out of our plan.</li> </ul>                                                                                                                                                                                          |
| <b>Accessibility and language assistance</b>                          | <ul style="list-style-type: none"> <li>You cannot physically access the health care services and facilities in a doctor or provider's office.</li> <li>Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish).</li> <li>Your provider does not give you other reasonable accommodations you need and ask for.</li> </ul> |
| <b>Waiting times</b>                                                  | <ul style="list-style-type: none"> <li>You have trouble getting an appointment or wait too long to get it.</li> <li>Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.</li> </ul>                                                                                                                                                          |
| <b>Cleanliness</b>                                                    | <ul style="list-style-type: none"> <li>You think the clinic, hospital or doctor's office is not clean.</li> </ul>                                                                                                                                                                                                                                                                                            |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Complaint                                           | Example                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Information you get from us                         | <ul style="list-style-type: none"> <li>You think we failed to give you a notice or letter that you should have received.</li> <li>You think written information we sent you is too difficult to understand.</li> </ul>                                                                                                                                                                                                                               |
| Timeliness related to coverage decisions or appeals | <ul style="list-style-type: none"> <li>You think we don't meet our deadlines for making a coverage decision or answering your appeal.</li> <li>You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services.</li> <li>You don't think we sent your case to the Independent Review Organization on time.</li> </ul> |

**There are different kinds of complaints.** You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call [\[insert contacts and contact information\]](#).

The legal term for a “complaint” is a “**grievance.**”

The legal term for “making a complaint” is “**filing a grievance.**”

## K2. Internal complaints

To make an internal complaint, call Member Services at [<phone number>](#). You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *[Insert additional description of the procedures (including time frames) and instructions about what members need to do if they want to use the process for making a complaint, including a fast complaint.]*

**The legal term for “fast complaint” is “expedited grievance.”**

If possible, we 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. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don’t make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don’t agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

### K3. External complaints

#### Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). You do not need to file a complaint with *[insert plan name]* before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

*[Insert additional Medicaid information as required by the state.]*

#### Office for Civil Rights



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

You can make a complaint to the Department of Health and Human Services Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for more information.

You may also contact the local Office for Civil Rights office at:

*[Plans should insert contact information for the OCR regional office.]*

You may also have rights under the Americans with Disability Act and under *[plans may insert relevant state law]*. You can contact *[insert contacts and contact information]*.

### Quality Improvement Organization

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the Quality Improvement Organization.
- You can make your complaint to the Quality Improvement Organization and to our plan. If you make a complaint to the Quality Improvement Organization, we work with them to resolve your complaint.

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. To learn more about the Quality Improvement Organization, refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook*.

In *<state>*, the Quality Improvement Organization is called *<state-specific QIO name>*. The phone number for *<state-specific QIO name>* is *<phone number>*.



**If you have questions**, please call *<plan name>* at *<toll-free phone and TTY numbers>*, *<days and hours of operation>*. The call is free. **For more information**, visit *<web address>*.

## Chapter 10: Ending your membership in our plan

### Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and *[Insert state-specific name of Medicaid program]* programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should edit this chapter as directed by the state to reflect Medicaid benefits such as if the plan can continue to provide Medicaid coverage when the member disenrolls from the Medicare plan or if the member is required to belong to a health plan to receive Medicaid benefits, etc..]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

**Commented [KG1]:** General Question: How does CMS envision the state making communications to the plans? And on what timeframe?

### Table of Contents

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

H. How to get more information about ending your plan membership ..... 9



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have [\[Insert state-specific name of Medicaid program\]](#), you may be able to end your membership with our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, **when**:

- You move out of our service area,
- Your eligibility for [\[Insert state-specific name of Medicaid program\]](#) or Extra Help changed, **or**
- If you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1** [\[insert reference, as applicable\]](#).
- Medicaid services in **Section C2** [\[insert reference, as applicable\]](#).

You can get more information about how you can end your membership by calling: [\[Insert any additional contact information as required by the state.\]](#)

**Commented [AA2]:** Instructions here should state that plans have the ability to add additional reasons for disenrollment

**Commented [SR3]:** This statement is only true from a MCR coverage perspective but does not represent the MCD disenrollment rules. So here we should indicate that a member's coverage to their MCR services could end before or after their coverage to their MCD coverage. This will ensure the members know HF could stop covering/paying for say hospital visits (MCR service) but continue to pay for in home nursing services (MCD service) for a period of time.

**Commented [KG4R3]:** Each reason has different time frames-process to make sure member has a safe discharge. This is only true for the Medicare side-we need an opportunity to input Medicaid information. 20th of each month. Suggested language: "If the plan submits the request for disenrollment before the 20th of the month you will be disenrolled from Medicaid the following month. If the plan submits the request for disenrollment after this date your disenrollment will be effective in two months."

**Commented [KG5R3]:** Min: allow flexibility to allow the NYS rules to be listed.

**Commented [AA6]:** Instructions should state the plans can add information state disenrollment timeframes



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP), *<State-specific SHIP name>* at *<phone number>*. *[TTY phone number is optional.]*

**NOTE:** If you're in a drug management program, you may not be able to change plans. Refer to **Chapter 5** of your *Member Handbook* for information about drug management programs.

## B. How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page <page number>.
- *[Insert if applicable: Call [insert name of state specific Medicaid program and contact information including TTY number]. Section C below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.]*

## C. How to get Medicare and *[Insert state-specific name of Medicaid program]* services separately

*[Update this section as needed to include appropriate Medicaid information.]* You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

### C1. Your Medicare services

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership *in* our plan.

**Commented [SR7]:** here we should tell the member that if they chose to get their Medicare services from another plan then HF will no longer be able to continue to provide their MCD services and vice versa if they choose to get their MCD services from somewhere else HF will no longer be able to continue to provide their MCR services under CC or HF connection.

**Commented [KG8R7]:** Need to make sure we have the freedom to input language reflecting the above. This is a large issue for integrated plans.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>1. You can change to:</b></p> <p><b>Another Medicare health plan</b></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p><i>[Insert if applicable: For PACE inquiries, call 1-855-921-PACE (7223).]</i></p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call the <i>[insert name of SHIP program]</i> at &lt;phone number&gt;. <i>[TTY phone number is optional.] [Insert as applicable: In &lt;state&gt;, the SHIP is called &lt;name of SHIP&gt;.]</i></li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare plan.</p> <p>You are automatically disenrolled from our Medicare plan when your new plan's coverage begins.</p> <p><i>[Insert any additional information regarding the impact of Medicaid enrollment as directed by the state.]</i></p> |
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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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| <b>2. You can change to:</b><br><br><b>Original Medicare with a separate Medicare prescription drug plan</b> | <b>Here is what to do:</b><br><br>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.<br><br>If you need help or more information: <ul style="list-style-type: none"><li>• Call the <i>[insert name of SHIP program]</i> at &lt;phone number&gt;. <i>[TTY phone number is optional.] [Insert as applicable: In &lt;state&gt;, the SHIP is called &lt;name of SHIP&gt;.]</i></li></ul><br><b>OR</b><br><br>Enroll in a new Medicare prescription drug plan.<br><br>You are automatically disenrolled from our plan when your Original Medicare coverage begins.<br><br><i>[Insert any additional information regarding the impact of Medicaid enrollment as directed by the state.]</i> |
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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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| <p><b>3. You can change to:</b></p> <p><b>Original Medicare without a separate Medicare prescription drug plan</b></p> <p><b>NOTE:</b> If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join.</p> <p>You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the <i>[insert name of state SHIP program]</i> at <i>[insert phone number]</i>, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local <i>[insert name of SHIP office]</i> office in your area, please visit <i>[insert web URL]</i>.</p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> <li>• Call the <i>[insert name of SHIP program]</i> at &lt;phone number&gt;. <i>[TTY phone number is optional.] [Insert as applicable: In &lt;state&gt;, the SHIP is called &lt;name of SHIP&gt;.]</i></li> </ul> <p>You are automatically disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert any additional information regarding the impact of Medicaid enrollment as directed by the state.]</i></p> |
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## C2. Your *[Insert state-specific name of Medicaid program]* services

*[Insert instructions specific to state Medicaid program as directed by the state.]*

## D. Your medical services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies *[insert if applicable: including through our mail-order pharmacy services]* to get your prescriptions filled.
- If you are hospitalized on the day that your membership in <plan name> ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

**Commented [SR9]:** in this section we may want to again talk about how MCR services may end before MCD services or vice versa

**Commented [KG10R9]:** *[Sylvester, Rachel]* Since this EOC is supposed to be for integrated plans as part of the feedback should we ask for a specific section from CMS that talks about "disconnected members"? As this is not an issue specific to HF it impacts all NYS MAP plans

**Commented [KG11R9]:** Opportunity to say that disenrollment date for Medicare v Medicaid might be different and how that impacts member services. Want to get across to members that if your Medicare coverage with HF ends, HF will not be proving Medicare Services. If you Medicaid coverage ends, HF will not be proving the Medicaid covered services.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## E. Other situations when your membership in our plan ends

These are cases when we must end **your** membership in our plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- *[Plans must insert rules for members who no longer meet special eligibility requirements.]*
- If you move out of our service area.
- If you are away from our service area for more than six months. *[Plans with visitor/traveler benefits should revise this bullet to indicate when the plan must disenroll members.]*
  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
  - *[Plans with visitor/traveler benefits, insert: Refer to **Chapter 4** of your **Member Handbook** for information on getting care through our visitor or traveler benefits when you're away from our plan's service area.]*
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance **you** have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

*[Insert deemed continuous eligibility information here, if applicable.]*

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

Commented [SR12]: i don't see death listed as a reason

Commented [KG13R12]: I believe we have the ability to add in other reasons, we would also need to add in (for CC) that the member needs 120 days or more of CBLTCs.

Commented [LJ14R12]: *[Sylvester, Rachel]* we report to LDSS per MAP contract to report death

Commented [KG15]: Grammar: insert "," after "insurance"



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your plan ID card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

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## F. Rules against asking you to leave our plan for any health-related reason

We cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

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## G. Your 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. You can also refer to **Chapter 9** of your *Member Handbook* for information about how to make a complaint.

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## H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 12: Definitions of important words

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### Introduction

This chapter includes key terms used throughout your *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans should insert additional definitions not included in this model and exclude model definitions not applicable to your plan, your contractual obligations with CMS or enrolled beneficiaries. Plans should modify definitions as appropriate in the state and/or as directed by the state.]*

*[When plans use key terms in the Member Handbook, they explain the term in the first section where it appears along with a reference to Chapter 12.]*

*[If plans revise terminology (e.g., "Member Services" to "Customer Service," "Care Coordinator" to "Care Manager") that affect glossary terms, plans use the revised term consistently throughout the Member Handbook and alphabetize it in this chapter.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



**Activities of daily living (ADL):** The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

**Aid paid pending:** You can continue getting your benefits while you are waiting for a decision about a Level 1 Appeal or a State Hearing (Refer to **Chapter 9** of your *Member Handbook* for more information). This continued coverage is called “aid paid pending.”

**Ambulatory surgical center:** A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

**Appeal:** A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your *Member Handbook* explains appeals, including how to make an appeal.

**Commented [KG1]:** Referencing the chapters is very helpful

**Behavioral Health:** An all-inclusive term referring to mental health and substance use disorders.

**Commented [KG2]:** Definition of Benefit Period is not included (it was in 2023 Model Materials) is this something we want? (We can also choose to add this on our own)

**Brand name drug:** A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

**Care coordinator:** One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

**Care plan:** Refer to “Individualized Care Plan.”

**Care team:** Refer to “Interdisciplinary Care Team.”

*[Plans with a single coverage stage should delete this paragraph.]* **Catastrophic coverage stage:** The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you reach the \$<TrOOP amount> limit for your prescription drugs.

**Centers for Medicare & Medicaid Services (CMS):** The federal agency in charge of Medicare. **Chapter 2** of your *Member Handbook* explains how to contact CMS.

**Complaint:** A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

**Comprehensive outpatient rehabilitation facility (CORF):** A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans that do not have copays should delete this paragraph.]* **Copay:** A fixed amount you pay as your share of the cost each time you get certain *[insert if applicable: services or]* prescription drugs. For example, you might pay \$2 or \$5 for *[insert if applicable: a service or]* a prescription drug.

*[Plans that do not have cost sharing should delete this paragraph.]* **Cost sharing:** Amounts you have to pay when you get certain *[insert if applicable: services or]* prescription drugs. Cost sharing includes copays.

*[Plans that do not have cost sharing should delete this paragraph.]* **Cost sharing tier:** A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List) is in one of *[insert number of tiers]* cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

**Coverage decision:** A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your *Member Handbook* explains how to ask us for a coverage decision.

**Covered drugs:** The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

**Covered services:** The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

**Cultural competence training:** Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

*[Plans that do not have cost sharing for Medicare Part D drugs should delete this paragraph. Plans may revise the information in this definition to reflect the appropriate number of days for their one-month supplies as well as the cost-sharing amount in the example.]* **Daily cost sharing rate:** A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost sharing rate is the copay divided by the number of days in a month's supply.

Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment is less than \$0.05 per day multiplied by 7 days, for a total payment less than \$0.35.

**Disenrollment:** The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans that do not have cost sharing add this paragraph.]* **Drug tiers:** Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of *[insert number of tiers]* tiers.

**Dual eligible special needs plan (D-SNP):** Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

**Durable medical equipment (DME):** Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

**Emergency:** A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function *[insert as applicable: (and if you are a pregnant woman, loss of an unborn child)]*. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

**Emergency care:** Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

**Exception:** Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

**Excluded Services:** Services that are not covered by this health plan.

**Extra Help:** Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

**Generic drug:** A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It’s usually cheaper and works just as well as the brand name drug.

**Grievance:** A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

**Health plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

**Health risk assessment:** A review of your medical history and current condition. It’s used to learn about your health and how it might change in the future.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**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 (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

**Hospice:** A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

**Improper/inappropriate billing:** A situation when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. Call Member Services if you get any bills you don't understand.

*[Plans with cost sharing, insert: As a plan member, you only pay our plan's cost sharing amounts when you get services we cover. We do **not** allow providers to bill you more than this amount.]*

*[Plans with no cost sharing, insert: Because we pay the entire cost for your services, you do **not** owe any cost sharing. Providers should not bill you anything for these services.]*

**Individualized Care Plan (ICP or Care Plan):** A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

*[Plans with a single coverage stage delete this paragraph.]* **Initial coverage stage:** The stage before your total Medicare Part D drug expenses reach \$*[insert initial coverage limit]*. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

**Inpatient:** A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

**Interdisciplinary Care Team (ICT or Care team):** A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**List of Covered Drugs (Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary.”

**Long-term services and supports (LTSS):** Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don’t have to go to a nursing facility or hospital. LTSS include Community Based Services and Nursing Facilities (NF).

**Low-income subsidy (LIS):** Refer to “Extra Help.”

*[Insert name of Medicaid program]*: This is the name of *[insert name of state]* Medicaid program. *[Insert name of Medicaid program]* is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medicaid (or Medical Assistance):** A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

**Medically necessary:** This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise and use the state-specific definition of “medically necessary” and update and use it consistently throughout member materials.]*

**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). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

**Medicare Advantage:** A Medicare program, also known as “Medicare Part C” or “MA,” that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

**Medicare-covered services:** Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part B.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Medicare-Medicaid enrollee:** A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual.”

**Medicare Part A:** The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

**Medicare Part B:** The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

**Medicare Part C:** The Medicare program, also known as “Medicare Advantage” or “MA,” that lets private health insurance companies provide Medicare benefits through an MA Plan.

**Medicare Part D:** The Medicare prescription drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

**Medicare Part D drugs:** Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

**Medication Therapy Management:** A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your *Member Handbook* for more information.

**Member (member of our plan, or plan member):** A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

**Member Handbook and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

**Member Services:** A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Member Handbook* for more information about Member Services.

**Network pharmacy:** A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Network provider:** “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

**Nursing home or facility:** A place that provides care for people who can’t get their care at home but don’t need to be in the hospital.

**Ombudsman:** An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. You can find more information in **Chapters 2 and 9** of your *Member Handbook*.

**Organization determination:** Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions.” **Chapter 9** of your *Member Handbook* explains coverage decisions.

**Original Medicare (traditional Medicare or fee-for-service Medicare):** The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don’t want to be in our plan, you can choose Original Medicare.

**Out-of-network pharmacy:** A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn’t cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

**Out-of-network provider or Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. **Chapter 3** of your *Member Handbook* explains out-of-network providers or facilities.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans that do not have cost sharing delete this paragraph.]* **Out-of-pocket costs:** The cost sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost sharing” above.

**Over-the-counter (OTC) drugs:** Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

**Part A:** Refer to “Medicare Part A.”

**Part B:** Refer to “Medicare Part B.”

**Part C:** Refer to “Medicare Part C.”

**Part D:** Refer to “Medicare Part D.”

**Part D drugs:** Refer to “Medicare Part D drugs.”

**Personal health information (also called Protected health information) (PHI):**

Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

*[Plans that do not use PCPs may omit this paragraph.]* **Primary care provider (PCP):** The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your *Member Handbook* for information about getting care from primary care providers.

**Prior authorization (PA):** *[Plans may delete applicable words or sentences if it does not require PA for any medical services or any drugs.]* An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of your *Member Handbook*.

Our plan covers some drugs only if you get PA from us.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs*.

**Program for All-Inclusive Care for the Elderly (PACE):** A program that covers Medicare and Medicaid benefits together for people age 55 and older who need a higher level of care to live at home.

**Prosthetics and Orthotics:** Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Quality improvement organization (QIO):** A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Member Handbook* for information about the QIO.

**Quantity limits:** A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

**Referral:** A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of your *Member Handbook*.

**Rehabilitation services:** Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Member Handbook* to learn more about rehabilitation services.

**Service area:** A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can **get our plan**.

**Commented [KG3]:** Suggest change the verbiage to "enroll in our plan"

*[Insert if applicable]* **Share of cost:** The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

**Skilled nursing facility (SNF):** A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

**Skilled nursing facility (SNF) care:** Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

**Specialist:** A doctor who provides health care for a specific disease or part of the body.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**State Hearing:** If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

**Step therapy:** A coverage rule that requires you to try another drug before we cover the drug you ask for.

**Supplemental Security Income (SSI):** A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently needed care:** Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Plans may add a back cover for the Member Handbook that contains contact information for Member Services. Below is an example plans may use. Plans also may add a logo and/or photographs, as long as these elements do not make it difficult for members to find and read the contact information.*

**Commented [KG4]:** Current EOC has: The Health Insurance Information Counseling and Assistance Program (HIICAP) (New York SHIP contact information on the back of it. Can we continue to add this in Chapter 12?

**Commented [AA5]:** Instructions should state that plans have the ability to add additional contact information

## <Plan name> Member Services

|                |                                                                                                                                                                                                                                                                                             |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <i>[Insert phone number(s).]</i><br><br>Calls to this number are free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i><br><br>Member Services also has free language interpreter services available for non-English speakers.    |
| <b>TTY</b>     | <i>[Insert number.]</i><br><br><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i><br><br>Calls to this number are free. <i>[Insert days and hours of operation.]</i> |
| <b>FAX</b>     | <i>[Optional: Insert fax number.]</i>                                                                                                                                                                                                                                                       |
| <b>WRITE</b>   | <i>[Insert address.]</i><br><br><i>[Note: Plans may add email addresses here.]</i>                                                                                                                                                                                                          |
| <b>WEBSITE</b> | <i>[Insert URL.]</i>                                                                                                                                                                                                                                                                        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Instructions to Health Plans

- ❖ *[Plans may include the ANOC in the 2024 Member Handbook (Evidence of Coverage) or provide it to members separately.]*
- ❖ *[Plans may modify the language in the ANOC, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]*
- ❖ *[Plans must use the state-specific name for Medicaid in references to “Medicaid” in any plan-customized language throughout the ANOC.]*
- ❖ *[Throughout the document update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medicaid plans, etc.).]*
- ❖ *[Where the ANOC uses “medical care,” “medical services,” or “health care services” to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]*
- ❖ *[Plans may change references to terms such as “member,” “customer,” “beneficiary,” “enrollee,” “member services,” “care coordinator,” “primary care provider,” “prior authorization (PA)” as instructed by the state or based on plan preference and update them consistently throughout the ANOC.]*
- ❖ *[Where the model material instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]*
- ❖ *[Throughout the ANOC, plans must follow the applicable style rules of the state, if any. For instance, where the model material instructs inclusion of a date or time, plans must use the specific format requested by the state Medicaid program. Other items covered by a state-specific style guide or similar document should also be updated accordingly.]*
- ❖ *[Plans should refer to the Member Handbook as needed using the appropriate chapter number, section, and/or page number. For example, “refer to Chapter 9, Section A, page 1.” An instruction [insert reference, as applicable] appears with many cross references throughout the ANOC and Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*
- ❖ *[Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).*
- *Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.*
- *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
- *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.*
- *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
- *Avoid separating a heading or subheading from the text that follows when paginating the model.*
- *Use universal symbols or commonly understood pictorials.*
- *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
- *Consider using regionally appropriate terms or common dialects in translated models.*
- *Include instructions and navigational aids in translated models in the translated language rather than in English.*
- *Consider producing translated models in large print.]*



<Plan name> [insert plan type] offered by [insert sponsor name]

# Annual Notice of Changes for 2024

[Optional: insert member name]

[Optional: insert member address]

## Introduction

[If there are any changes to the plan for 2024, insert: You are currently enrolled as a member of our plan. Next year, there will be some changes to our [insert as applicable: benefits, coverage, rules, [and] costs]. This [insert as applicable: section or Annual Notice of Changes] tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at [insert URL]. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.]

[If there are no changes whatsoever for 2024 (e.g., no changes to benefits, coverage, rules, costs, networks), insert: You are currently enrolled as a member of our plan. Next year, there are no changes to our benefits, coverage, [and] rules [insert if applicable: and costs]. However, you should still read this [insert as applicable: section or Annual Notice of Changes] to learn about your coverage choices. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at [insert URL]. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.]

[Any plan that does not include a particular section (e.g., Section C, Section F) deletes the section, orders all remaining sections and subsections sequentially, and updates the Table of Contents accordingly. Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## A. Disclaimers

❖ *[Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidance and included in any state-specific guidance provided by <insert state>.] [Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, here.]*

## B. Reviewing your Medicare and *[Insert name of Medicaid program]* coverage for next year

It is important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section E** for more information.

If you choose to leave our plan, your membership will end on the last day of the month in which your request was made. You will still be in the Medicare and *[Insert name of Medicaid program]* programs as long as you are eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section G2** *[insert reference, as applicable]*.
- *[Insert name of Medicaid program]* services in **Section G2** *[insert reference, as applicable]*.

**Commented [AA1]:** Plan should be able to edit this paragraph. This is not accurate for one of our plans and will need to be updated to reflect state guidelines regarding disenrollment. Depending on when the disenrollment is submitted to the state, it can be the second month after the disenrollment is submitted (pull down date).



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## B1. Additional resources

- ATTENTION: If you speak *[insert language of the disclaimer]*, language assistance services, free of charge, are available to you. Call *[insert Member Services toll-free phone and TTY numbers, and days and hours of operation]*. The call is free. *[This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation.]*
- You can get this *[Insert as applicable: section or Annual Notice of Changes]* for free in other formats, such as large print, braille, or audio. Call *[insert Member Services toll-free phone and TTY numbers, and days and hours of operation]*. The call is free.
- *[Plans also simply describe:*
  - *how they request a member's preferred language other than English and/or alternate format,*
  - *how they keep the member's information as a standing request for future mailings and communications so the member does not need to make a separate request each time, and*
  - *how a member can change a standing request for preferred language and/or format.]*

## B2. Information about *<plan name>*

- *[Insert plan's legal or marketing name]* is a health plan that contracts with both Medicare and Medicaid to provide benefits of both programs to members.
- Coverage under *[insert plan name]* is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.
- When this *Annual Notice of Changes* says "we," "us," "our," or "our plan," it means *[insert plan name]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### B3. Important things to do

- **Check if there are any changes to our benefits** *[insert if applicable: and costs]* that may affect you.
  - Are there any changes that affect the services you use?
  - Review benefit *[insert if applicable: and cost]* changes to make sure they will work for you next year.
  - Refer to **Section E1** for information about benefit *[insert if applicable: and cost]* changes for our plan.
- **Check if there are any changes to our prescription drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different *[insert if applicable: cost-sharing]* tier? Can you use the same pharmacies?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section E2** for information about changes to our drug coverage.
  - *[All plans with any Medicare Part D cost sharing insert: Your drug costs may have risen since last year.*
    - Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year.
    - Keep in mind that your plan benefits determine exactly how much your own drug costs may change.]
- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section D** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
  - *[Insert if applicable: How much will you spend out-of-pocket for the services and prescription drugs you use regularly?]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- How do the total costs compare to other coverage options?
- **Think about whether you are happy with our plan.**

**If you decide to stay with <2024 plan name>:**

If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in <2024 plan name>.

**If you decide to change plans:**

*[Plans should revise this paragraph as necessary]* If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section G2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

---

**C. Changes to our plan name**

*[Plans that are not changing the plan name, delete this section. Plans with an anticipated name change at a time other than January 1 may modify the date below as necessary.]*

On January 1, 2024, our plan name changes from <2023 plan name> to <2024 plan name>.

*[Insert language to inform members whether they will get new plan ID cards and how, as well as how the name change affects any other member communication.]*

---

**D. Changes to our network providers and pharmacies**

*[Plans with no changes to network providers and pharmacies insert: We have not made any changes to our network of providers and pharmacies for next year.]*

However, it's important that you know that we may make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook*.

*[Plans with changes to provider and/or pharmacy networks, insert: Our [insert if applicable: provider] [and] [insert if applicable: pharmacy] network[s] [insert as applicable: has or have] changed for 2024.]*

Please **review the 2024 Provider and Pharmacy Directory** to find out if your providers or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

website at <web address>. You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook*.]

---

**E. Changes to benefits [insert if applicable: and costs] for next year**

**E1. Changes to benefits [insert if applicable: and costs] for medical services**

[If there are no changes in benefits or in cost sharing, replace the rest of the section with: There are no changes to your benefits [insert if applicable: or amounts you pay] for medical services. Our benefits [insert if applicable: and what you pay for these covered medical services] will be exactly the same in 2024 as they are in 2023.]

We're changing our coverage for certain medical services [insert if applicable: and what you pay for these covered medical services] next year. The table below describes these changes.

[The table must include:

- All new benefits that will be added or 2023 benefits that will end for 2024;
- New or changing limitations or restrictions, including prior authorizations (PA), on benefits for 2024; **and**
- All changes in cost sharing for 2024 for covered medical services, including any changes to service category out-of-pocket maximums.]



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                              | 2023 (this year)                                                                                                                                                                                                                                                                                               | 2024 (next year)                                                                                                                                                                                                                                                                                                  |
|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>[Insert benefit name]</i> | <i>[For benefits that were not covered in 2023, insert:<br/><br/>[insert benefit name] is <b>not</b> covered.]<br/><br/>[For benefits with a copay insert:<br/><br/>You pay a \$&lt;2023 copay amount&gt; copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].]</i> | <i>[For benefits that will not be covered in 2024, insert:<br/><br/>[insert benefit name] is <b>not</b> covered.]<br/><br/>[For benefits with a copay insert:<br/><br/>You pay a \$&lt;2024 copay amount&gt; copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].]</i> |
| <i>[Insert benefit name]</i> | <i>[Insert 2023 cost or coverage, using format described above.]</i>                                                                                                                                                                                                                                           | <i>[Insert 2024 cost or coverage, using format described above.]</i>                                                                                                                                                                                                                                              |

**E2. Changes to prescription drug coverage**

**Changes to our Drug List**

*[Plans that did not include a List of Covered Drugs in the envelope, insert: You will get a 2024 List of Covered Drugs in a separate mailing.]*

*[Plans that did not include a List of Covered Drugs in the envelope and will not mail it separately unless requested, insert: An updated List of Covered Drugs is located on our website at <web address>. You may also call Member Services at the numbers at the bottom of the page for updated drug information or to ask us to mail you a List of Covered Drugs.]*

*[Plans that included a List of Covered Drugs in the envelope, insert: We sent you a copy of our 2024 List of Covered Drugs in this envelope.] The List of Covered Drugs is also called the “Drug List.”*

*[Plans with no changes to covered drugs, tier assignment, or restrictions may replace the rest of this section with: We have not made any changes to our Drug List for next year. However, we are allowed to make changes to the Drug List from time to time throughout the year, with approval from Medicare and/or the state. Refer to the 2024 Drug List for more information.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs.

Review the Drug List to **make sure your drugs will be covered next year** and to find out if there are any restrictions.

If you are affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
  - You can call Member Services at the numbers at the bottom of the page [\[insert if applicable: or contact your care coordinator\]](#) to ask for a list of covered drugs that treat the same condition.
  - This list can help your provider find a covered drug that might work for you.
- [\[Plans should include the following language if they have an advance transition process for current members:\]](#) Work with your doctor (or other prescriber) and ask us to make an exception to cover the drug.
  - You can ask for an exception before next year, and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement).
  - To learn what you must do to ask for an exception, refer to **Chapter 9** of your *Member Handbook* or call Member Services at the numbers at the bottom of the page.
  - If you need help asking for an exception, contact Member Services [\[insert if applicable: or your care coordinator\]](#). Refer to **Chapters 2 and 3** of your *Member Handbook* to learn more about how to contact your care coordinator.
- [\[Plans should include the following language if all current members will not be transitioned in advance for the following year:\]](#) Ask us to cover a temporary supply of the drug.
  - In some situations, we cover a **temporary** supply of the drug during the first [\[must be at least 90\]](#) days of the calendar year.
  - This temporary supply is for up to [\[insert supply limit \(must be the number of days in plan's one-month supply\)\]](#) days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
  - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

different drug our plan covers or ask us to make an exception for you and cover your current drug.

*[Plans may include additional information about processes for transitioning current enrollees to formulary drugs when your formulary changes relative to the previous plan year.]*

*[Include language to explain whether current formulary exceptions will still be covered next year or a new one needs to be submitted.]*

**Changes to prescription drug costs** *[option for plans with two drug payment stages]*

*[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), should include the following information in the ANOC.]*

*[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]*

There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

**Commented [AA2]:** Instructions should state that plans with no out-of-pocket costs can omit this section about coverage stages.

| Stage 1<br>Initial Coverage Stage                                                                                                                                                                        | Stage 2<br>Catastrophic Coverage Stage                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay.<br><br>You begin this stage when you fill your first prescription of the year. | During this stage, the plan pays all of the costs of your drugs through December 31, 2024.<br><br>You begin this stage after you pay a certain amount of out-of-pocket costs. |

The Initial Coverage Stage ends when your total out-of-pocket costs for prescription drugs reaches *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you will pay for prescription drugs.

**E3. Stage 1: “Initial Coverage Stage”**

During the Initial Coverage Stage, our plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Insert if applicable: We moved some of the drugs on our Drug List to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our Drug List.]*

The following table shows your costs for drugs in each of our *[insert number of tiers]* drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

*[Plans must list all drug tiers in the following table.]*

|                                                                                                                                                                                                                           | 2023 (this year)                                                                                                                                           | 2024 (next year)                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |

The Initial Coverage Stage ends when your total out-of-pocket costs reach *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point the Catastrophic Coverage Stage begins. The plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information how much you pay for prescription drugs.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



**E4. Stage 2: “Catastrophic Coverage Stage”**

When you reach the out-of-pocket limit *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]* for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year.

- *[Plans that do not reduce the copays for [insert name of the Medicaid program]-covered drugs in the catastrophic coverage stage should insert the following language: To locate more information about your prescriptions that Medicare and [insert name of the Medicaid program] cover, refer to the List of Covered Drugs, [insert reference, as applicable].]*

**Changes to prescription drug costs** *[option for plans with a single payment stage]*

*[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following information.]*

*[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]*

*[Insert if applicable: We moved some of the drugs on the Drug List to a lower or higher drug tier. [Insert if applicable: If your drugs move from tier to tier, this could affect your copay.] To find out if your drugs are in a different tier, look them up in the Drug List.]*

The following table shows your costs for drugs in each of our *[insert number of tiers]* drug tiers.

*[Plans must list all drug tiers in the following table.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                           | 2023 (this year)                                                                                                                                           | 2024 (next year)                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |

**F. Administrative changes**

*[Insert this section if applicable. Plans with administrative changes that impact members (e.g., change in contract or PBP number) may insert this section, include an introductory sentence that explains the general nature of administrative changes, and describe the specific changes in the table below. Plans that choose to omit this section should renumber the remaining sections as needed.]*

|                                                                                   | 2023 (this year)                                | 2024 (next year)                                |
|-----------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <i>[Insert a description of the administrative process/item that is changing]</i> | <i>[Insert 2023 administrative description]</i> | <i>[Insert 2024 administrative description]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                   | 2023 (this year)                                | 2024 (next year)                                |
|-----------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <i>[Insert a description of the administrative process/item that is changing]</i> | <i>[Insert 2023 administrative description]</i> | <i>[Insert 2024 administrative description]</i> |

## G. Choosing a plan

### G1. Staying in our plan

We hope to keep you as a plan member. You do not have to do anything to stay in our plan. If you do **not** change to another Medicare plan or change to Original Medicare, you automatically stay enrolled as a member of our plan for 2024.

### G2. Changing plans

*[Plans should add any additional Medicaid information as directed by the state.]* Most people with Medicare can end their membership during certain times of the year. Because you have *[Insert name of Medicaid program]*, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You moved out of our service area,
- Your eligibility for *[Insert name of Medicaid Program]* or Extra Help changed, **or**

**Commented [AA3]:** Add instructions here to say that plans can add bullets to include situations that are outlined in the state contract.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

**Your Medicare services**

You have three options for getting your Medicare services. By choosing one of these options, you automatically end your membership in our plan. *[Insert additional option to change to another integrated program as directed by the state.]*

|                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>1. You can change to:</b></p> <p><b>Another Medicare health plan</b> <i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>For PACE inquiries, call 1-855-921-PACE (7223).</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call the <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i> For more information or to find a local <i>[insert name of SHIP office]</i> office in your area, please visit <i>[insert website address]</i>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare plan.</p> <p>You will automatically be disenrolled from our plan when your new plan’s coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>2. You can change to:</b></p> <p><b>Original Medicare with a separate Medicare prescription drug plan</b></p> <p><i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i> For more information or to find a local <i>[insert name of office]</i> office in your area, please visit <i>[insert website address]</i>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare prescription drug plan.</p> <p>You will automatically be disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>3. You can change to:</b></p> <p><b>Original Medicare without a separate Medicare prescription drug plan</b></p> <p><i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> <p><b>NOTE:</b> If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join.</p> <p>You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i></li></ul> <p>You will automatically be disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Your *[insert name of state Medicaid program]* services**

For questions about how to get your *[insert name of Medicaid program]* services after you leave our plan, contact *[insert name of program, phone number, days and hours of operation, and TTY number and website if applicable]*. Ask how joining another plan or returning to Original Medicare affects how you get your *[insert name of Medicaid program]* coverage.

**H. Getting help**

**H1. Our plan**

We're here to help if you have any questions. Call Member Services at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

**Read your *Member Handbook***



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits *[insert if applicable: and costs]* for 2024. It explains your rights and the rules to follow to get services and prescription drugs we cover.

*[If the ANOC is sent or provided separately from the Member Handbook, include the following: The Member Handbook for 2024 will be available by October 15.] [Insert if applicable: You can also review the <attached or enclosed or separately mailed> Member Handbook to find out if other benefit [insert if applicable: or cost] changes affect you.]* An up-to-date copy of the *Member Handbook* is available on our website at *<web address>*. You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2024.

#### **Our website**

You can visit our website at *<web address>*. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our Drug List (*List of Covered Drugs*).

#### **H2. *[Insert name of the State Health Insurance Assistance Program (SHIP)]***

You can also call the State Health Insurance Assistance Program (SHIP). In *[Insert name of state]* the SHIP is called the *[Insert name of program]*. *[Insert name of program staff]* can help you understand your plan choices and answer questions about switching plans. *[Insert name of program]* HICAP is not connected with us or with any insurance company or health plan. *[Insert name of program]* has trained counselors *[insert in every county or locations]* and services are free. *[Insert name of program]* phone number is *[TTY phone number is optional.]* For more information or to find a local *[Insert name of program]* office in your area, please visit *[insert website address]*.

#### **H3. *[Insert State-specific name for ombudsman program]***

*[Insert this section if there is an ombudsman program in the state. Include a description of what the program can do, whether the services are free, and phone number. Please refer to an example of language below.]*

*[Optional language example: The Ombudsman Program can help you if you have a problem with our plan. The ombudsman's services are free and available in all languages. The Ombudsman Program:*

- Works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do.*
- Makes sure you have information related to your rights and protections and how you can get your concerns resolved.*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Is not connected with us or with any insurance company or health plan. The phone number for the Ombudsman Program is [insert phone number].*

#### **H4. Medicare**

To get information directly from Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

##### **Medicare's Website**

You can visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to [www.medicare.gov](http://www.medicare.gov) and click on "Find plans.")

##### **Medicare & You 2024**

You can read the *Medicare & You 2024* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf](http://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf)) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

*[Insert any additional sections as required by the state, such as the QIO or additional resources that might be available.]*

#### **H5. *[Insert state-specific name of Medicaid program.]***

*[Insert a description of the state Medicaid program's role and how to receive assistance from the state.]*

#### **H6. *[Insert additional resources if applicable]***

*[If applicable, insert a new section for each additional resource, including contact information and a description of their role.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## <Plan name> **Member Handbook**

- ❖ *[Plans may add a front cover to the Member Handbook that contains information such as the plan name, Member Handbook title, and contact information for Member Services. Plans may add a logo and/or photographs to the front cover as long as these elements do not make it difficult for members to read other information on the cover. If plans add a front cover, it must contain the Material ID.]*
- ❖ *[Plans must use the state-specific name for Medicaid in references to “Medicaid” in any plan-customized language throughout the Member Handbook.]*
- ❖ *[Plans may modify the language in the Member Handbook, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]*
- ❖ *[Throughout the document plans should update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medicaid plans, etc.)]*
- ❖ *[Where the Member Handbook uses “medical care,” “medical services,” or “health care services” to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]*
- ❖ *[Plans may change references to terms such as “member,” “customer,” “beneficiary,” “member services,” “health risk assessment,” “care coordinator,” “primary care provider,” “prior authorization (PA),” “nursing facility”, and “urgently needed care”, etc. as instructed by the state or based on plan preference and update them consistently throughout the Member Handbook.]*
- ❖ *[Where the model material instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]*
- ❖ *[Throughout the Member Handbook, in addition to following all Medicare and Medicaid requirements in regulation and the Medicare Communications and Marketing Guidelines, plans must follow additional applicable style rules of the state, if any.]*
- ❖ *[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number as appropriate. For example, “refer to Chapter 9, Section A, page 1.” An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*
- ❖ *[Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).*
- *Ensure plan-customized text is in plain language and complies with reading level requirements established in by the state.*
- *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
- *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.*
- *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
- *Avoid separating a heading or subheading from the text that follows when paginating the model.*
- *Use universal symbols or commonly understood pictorials.*
- *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
- *Consider using regionally appropriate terms or common dialects in translated models.*
- *Include instructions and navigational aids in translated models in the translated language rather than in English.*
- *Consider producing translated models in large print.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

<start date> – <end date>

## Your Health and Drug Coverage under <plan name>

*[Plans: Revise this language to reflect that the organization is providing both Medicaid and Medicare covered benefits, when applicable.]*

*[Optional: Insert member name.]*

*[Optional: Insert member address.]*

### **Member Handbook Introduction**

This *Member Handbook*, otherwise known as the *Evidence of Coverage*, tells you about your coverage under our plan through <end date>. It explains health care services *[plans may add references to other behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports, as needed]*. Key terms and their definitions appear in alphabetical order in Chapter 12 of your *Member Handbook*.

**This is an important legal document. Keep it in a safe place.**

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means *[insert plan name]*.

ATTENTION: If you speak *[insert language of the disclaimer]*, free language assistance services are available to you. Call <plan name> Member Services at the number at the bottom of this page. The call is free. *[This disclaimer must be included in all non-English languages that meet the Medicare or state thresholds for translation.]*

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

*[Plans also simply describe:*

- *how they request a member's preferred language other than English and/or alternate format,*
- *how they keep the member's information as a standing request for future mailings and communications so the member does not need to make a separate request each time, **and***
- *how a member can change a standing request for preferred language and/or format.]*

*[Plans must include an overall Table of Contents for the Member Handbook after the Member Handbook Introduction and before the Member Handbook Disclaimers.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Disclaimers

- ❖ *[Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidelines, and included in any state-specific guidance.]*
- ❖ *[Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, [here](#).]*
- ❖ Coverage under *[insert plan name]* is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 1: Getting started as a member

---

### Introduction

This chapter includes information about *[insert plan name]*, a health plan that *[insert description of the relationship such as covers or coordinates]* all of your Medicare and *[insert name of Medicaid program]* services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## A. Welcome to our plan

*[Insert language to describe the relationship between the Medicare and Medicaid services. For example: Our plan provides Medicare and [insert name of Medicaid program] services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.]*

*[Plan can include language about itself.]*

---

## B. Information about Medicare and *[Insert name of Medicaid Program]*

### B1. Medicare

Medicare is the federal health insurance program for:

- People 65 years of age or older,
- Some people under age 65 with certain disabilities, **and**
- People with end-stage renal disease (kidney failure).

### B2. *[Insert name of Medicaid Program]*

*[Insert name of the Medicaid program]* is the name of *[insert name of state]* Medicaid program. *[Insert name of Medicaid program]* is run by the state and is paid for by the state and the federal government. *[Insert name of Medicaid program]* helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- What counts as income and resources,
- Who is eligible,
- What services are covered, **and**
- The cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

*[Plans should revise this section to best reflect the coverage of the plan.]* Medicare and the state of *[insert name of state]* approved our plan. You can get Medicare and *[insert name of state Medicaid program]* services through our plan as long as:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We choose to offer the plan, **and**
- Medicare and the State of *[insert name of state]* allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and *[insert name of state program]* services is not affected.

---

## C. Advantages of our plan

*[Plans should revise this section to best reflect the coverage of the plan.]* You will now get all your covered Medicare and *[Insert name of Medicaid program]* services from our plan, including prescription drugs. **You do not pay extra to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **all** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

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## D. Our plan's service area

*[Insert plan service area here or within an appendix. Include a map if one is available.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



*Use county name only if approved for entire county, for example: Our service area includes these counties in <State>: <counties>.*

*For an approved partial county, use county name plus approved ZIP code(s) that are excluded, for example: Our service area includes all parts of <county> with the exception of the following ZIP code(s): <ZIP code(s)>.*

*If needed, plans may insert a table with more than one row or a short, bulleted list to describe and illustrate their service area in a way that is easy to understand.]*

Only people who live in our service area can join our plan.

**You cannot stay in our plan if you move outside of our service area.** Refer to **Chapter 8** of your *Member Handbook* for more information about the effects of moving out of our service area.

---

## E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- Live in our service area, **and**
- Have both Medicare Part A and Medicare Part B, **and**
- *Are currently eligible for [insert name of state Medicaid program], and*
- *[Insert any Medicaid requirements], and*
- Are a United States citizen or are lawfully present in the United States.

If you lose eligibility but can be expected to regain it within *[Insert number 1-6. Plans may choose any length of time from one to six months for deeming continued eligibility, as long as they apply the criteria consistently across all members and fully inform members of the policy.]* month(s), then you are still eligible for our plan.

Call Member Services for more information.

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## F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date *[Plans adjust this language if the state requirement is more stringent]*.

**Commented [SR1]:** Since a member's effective date of enrollment in HF connection or CC can be different b/w CMS vs the state do we want to ask CMS to add language that indicates the member's coverage effective date for access to MCR services might be different from their coverage effective date for access to MCD services?

**Commented [SR2]:** The MCD requirements would be different across CC and HF connection so as long as this section can be different for these two products then this meets our needs. I would also confirm this is the area where we would specify requirements specific to individuals qualifying for Long term care services which does not apply to HF connection

**Commented [SR3]:** The timeline for members to regain MCD eligibility while remaining enrolled with HF is different b/w Complete Care and HF connection so as long as this section can be different across these two products this will meet our needs

**Commented [KG4R3]:** 90 days for both CC and CNX



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs [\[add additional areas covered by HRA\]](#).

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

*[Plans may add additional language regarding information about joining the plans as directed by the state such as information about a continuity of care period or using doctors for a transition period.]*

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## G. Your care team and care plan

### G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, or other health person that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

### G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and [\[Insert as applicable: LTSS or other services\]](#).

Your care plan includes: [\[Update the description of the care plan and the process as outlined in your model of care \(MOC\)\]](#).

- Your health care goals.
- A timeline for getting the services you need.

Your care team meets with you after your health risk assessment. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H. Your monthly costs for *[insert plan name]*

*[Plans should revise this section to only include premium types that apply or delete if plan has no monthly premium and revise with “Our plan has no premium.”]*

Your costs may include the following:

- Plan premium (Section H.1)
- Monthly Medicare Part B Premium (Section H.2)
- Optional Supplemental Benefit Premium (Section H.3)

**In some situations, your plan premium could be less.**

*[Insert as appropriate, depending on whether SPAPs are discussed in Chapter 2: There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. OR The “Extra Help” program helps people with limited resources pay for their drugs.]* Chapter 2, Section H2 tells more about *[insert as applicable: these programs OR this program.]* If you qualify, enrolling in the program might lower your monthly plan premium.

If you *already enrolled* and are getting help from one of these programs, **the information about premiums in this *Member Handbook* *[insert as applicable: may OR does]* not apply to you.** *[If not applicable, omit information about the LIS Rider.]* We *[insert as appropriate: have included OR sent you]* a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

### H1. Plan premium

*[If applicable, plans should revise this section to indicate that the plan premium is paid on behalf of members (e.g. by “Extra Help”, Medicaid).]*

As a member of your plan, you pay a monthly plan premium. *[Select one of the following: For 2024, the monthly premium for *[insert 2024 plan name]* is *[insert monthly premium amount]*. OR The monthly premium amount for *[insert 2024 plan name]* is listed in *[describe attachment.]* *[Plans may insert a list or table with the state/region and monthly plan premium amount for each area included within the EOC. Plans may also include premium(s) in an attachment to the EOC.]**

*[Plans with no premium should delete this section.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H2. Monthly Medicare Part B Premium

### Many members are required to pay other Medicare premiums

*[Plans that include a Medicare Part B premium reduction benefit may describe the benefit within this section.]*

*[Plans that do not have any members paying Medicare premiums or plans whose members must pay the full Medicare Part B premium should modify this section.]*

*[Plans with no monthly premium, omit: In addition to paying the monthly plan premium,]* some members are required to pay other Medicare premiums. As explained in Section H2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most *[insert 2024 plan name]* members, Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and for your Medicare Part B premium.

**If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.** This includes your premium for Medicare Part B. It may also include a premium for Medicare Part A which affects members who aren't eligible for premium free Medicare Part A. **In addition, please contact Member Services or your care coordinator and inform them of this change.**

### H3. Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called "optional supplemental benefits," then you pay additional premium each month for these extra benefits. Refer to Chapter 4, Section E for details. *[If the plan describes optional supplemental benefits within Chapter 4, then the plan must include the premium amounts for those benefits in this section.]*

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## I. Your Member Handbook

Your *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* found on our website *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

The contract is in effect for the months you are enrolled in our plan between *[insert start date]* and *[insert end date]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, *[insert if applicable: information about how to access]* a *Provider and Pharmacy Directory*, *[plans that limit DME brands and manufacturers insert: a List of Durable Medical Equipment,]* and *[insert if applicable: information about how to access]* a *List of Covered Drugs*, also known as a *Formulary*.

### J1. Your Member ID Card

Under our plan, you have one card for your Medicare and *[insert name of Medicaid program]* services, including long-term services and supports, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:

*[Insert picture of front and back of plan ID card. Mark it as a sample card (for example, by superimposing the word “sample” on the image of the card).]*

If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your *[insert name of Medicaid program]* card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Member Handbook* to find out what to do if you get a bill from a provider.

*[If members must use a different card for any Medicaid services, include a description here.]*

### J2. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Provider and Pharmacy Directory* at *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

*[Plans must add information describing the information available in the directory.]*

*[Plans may add information describing the use of providers during a transition period as directed by the state.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Definition of network providers**

- Our network providers include:
  - Doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - LTSS, behavioral health services, home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

**Definition of network pharmacies**

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to [\[insert if applicable: help you\]](#) pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

*[Plans that limit DME brands and manufacturers insert the following section (for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual:*

**List of Durable Medical Equipment (DME)**

We sent you our List of Durable Medical Equipment (DME) with this *Member Handbook*. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at the address at the bottom of the page. Refer to **Chapters 3 and 4** of your *Member Handbook* to learn more about DME equipment.]

**J3. List of Covered Drugs**

The plan has a *List of Covered Drugs*. We call it the “Drug List” for short. It tells you which prescription drugs our plan covers.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Member Handbook* for more information.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Each year, we send you [\[insert if applicable: information about how to access\]](#) the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website [at the address at the bottom of the page](#). [\[Plans may insert information about Medicaid covered drugs.\]](#)

#### J4. The Explanation of Benefits

When you use your Medicare Part D prescription drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D prescription drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take [\[insert, as applicable: such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options\]](#).

**Chapter 6** of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

[\[Plans may insert other methods for members to get their EOB.\]](#)

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## K. Keeping your membership record up to date

[\[In the Table of Contents, section heading, and text, plans substitute the name for this file if it differs from "membership record."\]](#)

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you.**

Tell us right away about the following:

- Changes to your name, your address, or your phone number.
- Changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation.
- Any liability claims, such as claims from an automobile accident.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Admission to a nursing facility or hospital.
- Care from a hospital or emergency room.
- Changes in your caregiver (or anyone responsible for you.)
- You take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

*[Plans that allow members to update this information online may describe that option here.]*

*[Plans may add information regarding keeping their Medicaid information updated as directed by the state.]*

### **K1. Privacy of personal health information (PHI)**

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-10824  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Submitted electronically via [regulations.gov](https://www.regulations.gov)

November 7, 2022

## **Re: Proposed Collection of Information: Integrated Annual Notice of Changes and Evidence of Coverage for Dual Eligible Special Needs Plans in Certain States (CMS-10824)**

Justice in Aging appreciates the opportunity to submit comments in response to the above-referenced proposed collection of information on the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents for people dually eligible for Medicare and Medicaid. Although the comments below focus primarily on the ANOC, the themes in our comments are also applicable to the EOC.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable healthcare, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income individuals and populations that have traditionally lacked legal protection such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Justice in Aging appreciates the efforts taken by CMS to improve the ANOC's readability and accessibility. This process is undeniably challenging, especially given the demographic diversity of people dually eligible for Medicare and Medicaid. Compared to Medicare-only recipients, dually eligible individuals are more likely to be female, Black or Latino, and limited in English proficiency (LEP). Additionally, 39% of people dually eligible for Medicare and Medicaid have less than a high school level of education. Given the intersectional identities and corresponding needs of individuals dually eligible for Medicare and Medicaid, our analysis focuses on facilitating more meaningful access to the ANOC's content.

### *Consumer Testing*

Gathering input about how to increase the linguistic and cultural relevance of the ANOC should begin with beneficiaries. To understand how consumers experience the ANOC, CMS should solicit feedback from diverse voices reflective of the demographic diversity of people dually eligible for Medicare and Medicaid. For example, listening sessions should be conducted in languages beyond English and Spanish. Including consumers in the ANOC development process can help CMS to deliver information in a more meaningful manner to people dually eligible for Medicare and Medicaid.

*Washington, DC*



*Los Angeles, CA*



*Oakland, CA*

Although consumer testing is needed to understand how beneficiaries interact with this document, our analyses identified opportunities to improve the document's readability. These suggestions include: making the document more personalized to the beneficiary; using plain and standardized language; implementing language and accessibility improvements to increase beneficiary understanding of the content; considering alternative methods, such as images and symbols, to convey the information in a more meaningful manner; and clarifying potentially confusing aspects of the document.

### *Personalization*

The ANOC is an important document, as it informs plan members of key changes that may influence their decision to continue membership in the plan. To that end, the ANOC should be person-centered, provide information with specificity, and deliver information in a user-friendly manner. To achieve its purpose, highlighting the upcoming changes to the plan at the beginning of the document quickly alerts enrollees of changes that may directly impact them. In its current form, information about plan changes does not appear until page 8 of the document. To make it easier for enrollees to comprehend upcoming changes, we suggest adding a summary with highlights or bullet points on the first or second page of the ANOC. For example, the summary section could flag that the plan name or prescription drug co-payments are changing and then reference the page number and accompanying section where the change is discussed in more detail. Given that changes could influence a consumer's decision to remain in the plan, information about how to change plans can also be raised earlier in the document than in its current location on page 16.

We also suggest that the document be personalized to the beneficiary. For example, on page 3, instead of giving Dual Eligible Special Needs Plans (D-SNPs) the option to address the document to the member by name, CMS should make using the individual's name a requirement.

### *Encourage the Use of Plain and Standardized Language*

The ANOC and EOC should use plain language when possible. Plans must explain acronyms and less common terms in consumer-friendly language and provide relevant examples. Long-term services and supports are referenced multiple times in the EOC chapters; although this is a common term used by health care providers and health plans, the meaning may be obscure to the average consumer. Examples are helpful to illustrate services offered under long-term services and supports or an explanation of how care coordination would benefit a consumer.

CMS should also consider developing standardized language to describe care coordination and care coordinators. While plans should continue to have the discretion to describe care coordination to some extent, developing standardized language or simple requirements, such as using examples, will ensure that all plans provide a basic description of care coordination that is meaningful.

## *Language and Accessibility Considerations*

Current regulations permit hard copies of the ANOC and EOC to be mailed or delivered electronically.<sup>1</sup> Plans should be required to mail these documents by default unless the consumer affirmatively elects to receive these communications by electronic mail. Dually eligible individuals may not have ready access to technology, may not frequently check email communications, or may need assistance using technological devices. As a default, these materials should be delivered by mail while allowing consumers to elect electronic delivery.

As previously indicated, people dually eligible for Medicare and Medicaid are more diverse than Medicare-only recipients. Therefore, analysis of the ANOC must consider how to improve the document's accessibility for subpopulations, including LEP enrollees. Information about alternative languages and formats is not found in the ANOC until page 6, section B1. To increase the prominence of information about translated materials and alternative formats in the ANOC, we suggest that CMS provide this information as an insert or cover sheet. Consumers that receive the ANOC in English, but need translated materials or alternative formats, may not read to page 6 of the document to learn they can receive these materials in the language or format they need. An insert or cover sheet quickly alerts the consumer that translated and alternative format materials are available and provides critical information on how to request these materials.

In addition to providing this information earlier in the document or as an insert, we encourage CMS to explore options to relay information about the plan's language and accessibility features in as many languages and formats as possible. For example, CMS might consider including an insert containing information about language assistance services and alternative document formats in the threshold languages in the plan's geographic area. In all respects, D-SNPs and Medicaid plans serving the same geographic area should be subject to the same language accessibility requirements, and should be whichever is most favorable to the beneficiary. It would be confusing for an enrollee to receive the ANOC and EOC in English and materials from their Medicaid plan in their preferred language. Additionally, information about language assistance services could be included at the bottom of every page of the document to improve access.

The ANOC currently contains optional language for plans. This content, for example, on page 2, provides plans with the option of using "regionally appropriate terms or common dialects in translated models." Regionally appropriate language is more likely to resonate with specific communities, improving the document's usability for particular subpopulations. When regionally appropriate terminology is available, this content should be included in the document and, to ensure relevance, be subject to beneficiary testing.

As another example, plans currently have the option of providing translated materials in large print. Accessibility features should be available to all enrollees, regardless of the language of the materials they receive. Therefore, plans should be required to provide translated materials in

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<sup>1</sup> 42 C.F.R. 422.2267(d).

large font, upon request, to consumers. We do not imagine that the requests for large print materials would be so great that they would cause a significant financial burden to health plans.

### *Alternative Methods of Relaying Content*

We encourage CMS to explore options beyond text to relay information in the ANOC. To demonstrate this need, consider the consumers that do not recognize their enrollment in Medicare until they are shown a picture of a Medicare card. Simple visuals, such as a pill to denote medicine or an apple to signify preventative care, as found in The Medicare & You handbook, help orient readers to the subject matter outlined in the accompanying text. Additional formatting choices in the handbook, such as charts, text boxes, and arrows containing the word “Important,” direct the reader to pay close attention to specific content while breaking up the dense text to make the document more visually accessible.<sup>2</sup> While formatting suggestions gathered from consumers, such as plain language and bulleted lists, have been incorporated into the document, additional efforts could be taken to advance the document’s accessibility. We encourage CMS to explore opportunities to use images and formatting alternatives to make the ANOC more user-friendly.

Beneficiary outreach is yet another method to enhance members’ understanding of their benefits. CMS might consider directing plans to discuss beneficiary-specific changes outlined in the ANOC with members as part of their ongoing case management duties. For example, the ANOC currently instructs members to contact Member Services to discuss changes related to their medication coverage. Instead of placing the sole responsibility of outreach on the beneficiary, we alternatively suggest that plans contact enrollees to discuss plan changes, answer questions, ensure access to accessibility features, and assist with benefits navigation. We believe that this additional support from plans will enhance members’ understanding of their benefits, improve access to critical resources like medications, and ultimately improve their health outcomes.

Precedence for this type of outreach already exists in California. Health plans participating in California’s Financial Alignment Initiative (FAI) are conducting telephone calls to their members to alert them of the transition into exclusively aligned D-SNPs.<sup>3</sup> Telephone calls are person-centered, ensure enrollees are aware of critical changes, and offer an opportunity for enrollees to ask questions about their plan.

### *Confusing Elements*

Our analysis identified a few areas of the ANOC that likely fuel confusion. For example, cost-sharing references throughout the document may confuse Qualified Medicare Beneficiaries (QMBs) or those full-benefit dual eligibles who do not have costs associated with their benefits. At the same time, removing cost-sharing references altogether may result in a need for more awareness amongst consumers of the savings related to their dual eligibility status. As this

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<sup>2</sup> Centers for Medicare and Medicaid Services, Medicare & You 2023, available at <https://www.medicare.gov/publications/10050-Medicare-and-You.pdf>.

<sup>3</sup> California Department of Health Care Services, [Managed Long-Term Services and Supports and Duals Integration Workgroup](#), at slide 34, October 19, 2022.

example demonstrates, beneficiary testing is needed to better understand how consumers interpret this information to improve messaging.

As another example, when the document encourages readers to reference a section of the ANOC or EOC, a brief explanation should accompany the section name to help the reader understand its content. We urge CMS to utilize language beyond “Refer to Section E,” as found on page 5, and instead use language like “Refer to Section E for information about changes to our drug coverage,” as seen on page 7. This additional information helps to orient the reader to the section’s content and makes the document easier to navigate.

### *Conclusion*

Justice in Aging appreciates concerted efforts on behalf of CMS to make the ANOC and EOC materials more accessible to persons dually eligible for Medicare and Medicaid. We look forward to working with the agency to implement these suggestions in order to enhance the quality of care for millions of people with Medicare and Medicaid. If any questions arise concerning this submission, please contact Tiffany Huyenh-Cho, Senior Staff Attorney, at [thuyenhcho@justiceinaging.org](mailto:thuyenhcho@justiceinaging.org) or Hannah Diamond, Policy Advocate, at [hdiamond@justiceinaging.org](mailto:hdiamond@justiceinaging.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Amber Christ". The signature is fluid and cursive, with the first name "Amber" and last name "Christ" clearly distinguishable.

Amber Christ  
Managing Director, Health Advocacy

**Kaiser Permanente Comments on  
CMS–10824, CMS– R–131 and CMS–10556:  
Annual Notice of Change and Evidence of Coverage for Applicable Integrated Plans in States that Require Integrated Materials**

*Submitted via [Regulations.gov](https://www.regulations.gov) on November 7, 2022*

Kaiser Permanente appreciates the opportunity to submit comments regarding the Annual Notice of Change and Evidence of Coverage for Applicable Integrated Plans in States that Require Integrated Materials. These documents are critical to ensuring beneficiaries understand their benefits and plan rules. Thank you in advance for consideration of this feedback. If there are any questions, please contact Jamie Brandi, Executive Director, Medicare Compliance at (510) 209-1877 or [Jamie.L.Brandi@kp.org](mailto:Jamie.L.Brandi@kp.org).

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Below we are providing comments and feedback on specific sections of the documents.

| Document Type | Section | Model Text                                                          | Recommended Change                                                                                                                                       | Rationale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------|---------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ANOC          | B3      | Are they in a different [insert if applicable: cost-sharing] tier?  | The plan recommends removing the sentence.                                                                                                               | For plans filing the Defined Standard benefit, if members lose Extra Help for their Part D drugs, they will have to pay the Defined Standard cost-sharing, which has no tiers in the benefit design. The reference to Part D drug tiers are not applicable to Defined Standard.                                                                                                                                                                                                             |
| ANOC          | E2 - E3 | Changes to prescription drug costs, Stage ICL, Stage 2 Catastrophic | The plan recommends adding language from the DE SNP ANOC and EOC models to describe the Defined Standard benefit and cost-sharing if a member loses LIS. | The two model language options (no cost-sharing/single payment stage and two stages) don't accurately describe the Part D Defined Standard coverage filed in the PBPs. If members lose Extra Help for their Part D drugs, they will have to pay the Defined Standard cost-sharing, which has four drug stages and is at a coinsurance for all drugs in ICL and Gap (no tiers). Members should refer to their LIS Rider, which is mailed separately, for their member-specific cost-sharing. |

| Document Type | Section             | Model Text                                                               | Recommended Change                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Rationale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------|---------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| EOC           | Ch. 1,<br>Section C | •You can work with us for all of your health care needs.                 | The plan recommends changing "all" to "most."                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | The plan will work with the member on most, not all, of their health care needs. For example, if a member needs a service not covered by our plan that is covered by Medicaid (for example, certain behavioral health services), the member may need to contact Medicaid agency directly to locate an out-of-network provider to provide the Medicaid covered care.                                                                                                                                                                                                                                                                                                                                                                                                            |
| EOC           | Ch. 1,<br>Section E | E. What makes you eligible to be a plan member                           | <p>You are eligible for our plan as long as you:</p> <ul style="list-style-type: none"> <li>• Live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.), and</li> <li>• Are age 21 and older at the time of enrollment, and</li> <li>• Have both Medicare Part A and Medicare Part B, and</li> <li>• Are currently eligible for Medicaid and [insert language as appropriate under terms of state contract], and</li> <li>• Are a United States citizen or are lawfully present in the United States.</li> </ul> | <p>The EOC and model Summary of Benefits (SB) language regarding eligibility does not align. Recommend adding the EOC language to the SB for consistency and accuracy, especially since the SB is a pre-enrollment document.</p> <p>"A Medicare-Medicaid Coordination Plan is a health plan that contracts with both Medicare and Medicaid to provide benefits of both programs to enrollees. <i>It is for people age 65 and older.</i> A Medicare-Medicaid Coordination Plan is an organization made up of doctors, hospitals, pharmacies, providers of Long-term Services and Supports (LTSS), and other providers. It also has care coordinators to help you manage all your providers and services and supports. They all work together to provide the care you need."</p> |
| EOC           | Ch. 2,<br>Section B | [Plans should include information on eligibility requirements for LTSS.] | Recommend giving plans flexibility based on specific services and eligibility requirements if applicable.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | LTSS can include long-term care as well as community supports and Community-based Adult Services. The appropriateness of those services is determined on a member-specific basis and generic language would not be appropriate.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

| Document Type | Section              | Model Text                                                               | Recommended Change                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Rationale                                                                                                                                                                                                                      |
|---------------|----------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| EOC           | Ch. 3,<br>Section E  | E. Behavioral health (mental health and substance use disorder) services | Recommend adding new language to address the subject more completely and accurately.                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Language should allow flexibility to reflect that Substance Use Disorder services are carved out of Medicaid managed care and note that specialty mental health services are the responsibility of county mental health plans. |
| EOC           | Ch. 3,<br>Section K1 | K1. DME as a member of our plan                                          | Recommend flexibility to describe DME coverage per State law.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Language does not reflect the definition of DME under state law.                                                                                                                                                               |
| EOC           | Ch. 4,<br>Section D  | Home health agency care                                                  | <p>Recommend removing or modifying the language in parenthesis to clarify as coverage is based on medical necessity:</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Part-time or intermittent skilled nursing and home health aide services (<i>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.</i>)</li> </ul> <p>...</p> | The number of hours as listed is confusing to members.                                                                                                                                                                         |



| Document Type | Section             | Model Text | Recommended Change | Rationale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------|---------------------|------------|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| EOC           | Ch. 4,<br>Section D | General    |                    | <p>The plan requests flexibility to modify the benefit chart appropriately to describe the integrated plans. The current structure for the benefits chart does not allow flexibility for plans to fully integrate disclosures for supplemental Medicare benefits or for situations in which Medicare and Medicaid coverage may differ. For example, the benefits chart specifies visit limits for acupuncture and limits services to low back pain. California Medicaid, however, allows for coverage as medically necessary and does not limit services to treatment of low back pain. Since the benefits chart does not expressly allow plans to integrate coverage disclosure, state agencies are requiring full inclusion of the CMS template language alongside the Medicaid disclosure. The result is a description that confuses members and is not a holistic reflection of our benefits under the integrated plan. Other examples include a myriad of screening services where Medicare limits coverage to one screening per year, but Medicaid does not impose quantity limits. Members would benefit from flexibility by plans to integrate coverage descriptions to allow for a comprehensive description for enrollees. Examples of such screening services where Medicare has limits but Medicaid does not include: alcohol misuse screening, depression screening, diabetes screening, HIV Screening, STI screening.</p> <p>Another example of overlapping coverage is diabetes prevention programs. Both Medicare and Medicaid cover diabetes prevention programs. However, the conditions of participation under the programs can differ. If a member exhausts their</p> |

| Document Type | Section                | Model Text                                                                                                                    | Recommended Change                                                                                                                            | Rationale                                                                                                                                                                                                                                                                                                                                                                    |
|---------------|------------------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|               |                        |                                                                                                                               |                                                                                                                                               | Medicare diabetes program, the member can invoke their Medicaid coverage. The benefits chart does not allow for flexibility to add disclosure for both programs.                                                                                                                                                                                                             |
| EOC           | Ch. 5,<br>Section B4   | B4. Drug list tiers                                                                                                           | Recommend flexibility to remove Section B4 to align with the Part D Defined Standard benefit that is filed in the PBPs.                       | For plans filing a Defined Standard benefit design in the PBPs for Part D drugs, if members lose Extra Help for their Part D drugs, they will have to pay the Defined Standard cost-sharing, which has no tiers in the benefit design. The reference to the Part D drug tiers is not relevant because they are not applicable to Defined Standard coverage in this scenario. |
| EOC           | Ch. 6,<br>Introduction | Which of the <number of tiers> [Plans that do not have cost sharing in any tier may omit: cost-sharing] tiers each drug is in | Recommend flexibility to remove the bullet about tiers in the Introduction to align with the Part D Defined Standard benefit.                 | For plans filing the Defined Standard benefit, if members lose Extra Help for their Part D drugs, they will have to pay the Defined Standard cost-sharing, which has no tiers in the benefit design. Thus, the reference to Part D drug tiers are not applicable to Defined Standard coverage.                                                                               |
| EOC           | Ch. 6,<br>Section B    | When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Part D drugs for the rest of the year. | Recommend flexibility to remove the sentence about Catastrophic Coverage to align with the to align with the Part D Defined Standard benefit. | For plans filing the Defined Standard benefit, if members lose Extra Help for their Part D drugs, they will have to pay the Defined Standard cost-sharing, which has cost-sharing in Catastrophic. The sentence is incorrect for members when they lose LIS.                                                                                                                 |

| Document Type | Section             | Model Text                                       | Recommended Change                                                                                                                                                                                                                                                                       | Rationale                                                                                                                                                                                                                                                                                                                                                          |
|---------------|---------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| EOC           | Ch. 6,<br>Section C | Drug Payment Stages for<br>Medicare Part D drugs | Recommend flexibility to add<br>language from the DE SNP<br>ANOC and EOC models to<br>describe the Defined Standard<br>benefit and cost-sharing if a<br>member loses LIS. This includes<br>four drug stages, no drug tiers,<br>and cost-sharing for Defined<br>Standard coverage stages. | For plans filing the Defined Standard benefit design<br>in the PBPs for Part D drugs, if members lose Extra<br>Help for their Part D drugs, they will have four drug<br>stages, no drug tiers, and have to pay the Defined<br>Standard cost-sharing. The current model has no<br>options for this coverage, which if not addressed is<br>confusing and inaccurate. |
| Templates     | ANOC/EOC            |                                                  |                                                                                                                                                                                                                                                                                          | The plan requests that final templates be provided<br>no later than early May, and final approvals from<br>the State by 8/1, to allow sufficient time for<br>development, quality review, translations, and print<br>production to meet the 9/30 (ANOC mailing) and<br>10/15 (online posting) deliverables.                                                        |



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November 7, 2022

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-10824  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Re: Proposed Collection of Information: Integrated Annual Notice of Changes and Evidence of Coverage for Dual Eligible Special Needs Plans in Certain States (CMS-10824)**

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Proposed Collection of Information: Integrated Annual Notice of Changes and Evidence of Coverage for Dual Eligible Special Needs Plans in Certain States (CMS-10824)**. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

We applaud the changes made to the communications for enrollees of Dual Eligible Special Needs Plans (D-SNPs). Better integrating information on Medicaid benefits will improve these communications and lead to more awareness and better decision making for D-SNP enrollees.

While our edits focus on the Annual Notice of Change (ANOC), we also reviewed the new Evidence of Coverage (EOC); our comments below largely apply to both documents.

**Consumer Testing**

We urge extensive use of consumer testing to ensure the ANOC and EOC achieve the right balance of information and approachability. Too much information is overwhelming, too little is useless. Generally speaking, we found the drafts had a good balance, but we are also aware that many readers may be approaching the material without previous knowledge of or understanding of how Medicare Advantage

works and what their rights and responsibilities are. We encourage testing around language, organization, and what information in the ANOC is necessary and what may be left to the EOC.

In all cases, our suggestions should be disregarded where they conflict with the results of consumer testing.

### **Readability and Formatting**

The new ANOC in particular is a marked improvement over past versions, with more streamlined text and more visual appeal, including better use of white space and readable fonts.

Though it would extend the length of the document, we encourage the use of tested graphics to guide readers and flag important details.

### **Accessibility and Language Access**

We urge clarifying what language help is available early on to ensure people see it immediately. The reference in the ANOC is not until B1. For comparison, in the Medicare & You Handbook, the information is on page two in the introduction.<sup>1</sup>

In addition, plans currently have the option of providing translated materials in large print. Accessibility features should be available to all enrollees, regardless of the language of the materials they receive.

### **Organization**

We suggest the use of cover sheets or early pages that list major or confusing changes with references pointing the reader to more information. The Medicare & You introduction (page two) could serve as a guide.

In addition, we suggest that some material may benefit from being introduced sooner in the ANOC:

- Information about help in other languages
- Information about plan changes, including plan name
- Information about what happens if the enrollee does not choose another plan

### **Potentially Confusing Elements**

We encourage the use of state-specific names for Medicaid and also the use of “Medicaid” to ensure enrollees understand both.

The ANOC does not include any information about Extra Help and similar low-income assistance programs, or identification of where to go to find information about such programs. We recommend adding this information to the introduction page, and throughout as appropriate.

The ANOC uses “copay” instead of “cost sharing.” This may be confusing if plans employ and refer to coinsurance. References to all forms of cost sharing should be clearly defined and used carefully, considering that Qualified Medicare Beneficiaries (QMBs) or some full-benefit dually eligible individuals may not have costs associated with their benefits and may be confused or dissuaded from seeking care if they believe they will incur costs.

### **Personalization**

We also urge personalization to the extent possible to ensure that people get information best tailored to their circumstances.

### **Conclusion**

Thank you again for the opportunity to provide comment. For additional information, please contact Lindsey Copeland, Federal Policy Director at [LCopeland@medicarerights.org](mailto:LCopeland@medicarerights.org) or 202-637-0961 and Julie Carter, Counsel for Federal Policy at [JCarter@medicarerights.org](mailto:JCarter@medicarerights.org) or 202-637-0962.

Sincerely,

A handwritten signature in cursive script that reads "Lindsey Copeland".

Lindsey Copeland  
Federal Policy Director  
Medicare Rights Center

## Chapter 2: Important phone numbers and resources

---

### Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[If applicable, plans should modify this chapter to include contact information for other resources.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## A. Member Services

|                |                                                                                                                                                                                                                                                                       |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <Phone number(s)> This call is free.<br><br><Days and hours of operation> <i>[Include information on the use of alternative technologies.]</i><br><br>We have free interpreter services for people who do not speak English.                                          |
| <b>TTY</b>     | <TTY phone number> This call is free.<br><br><i>[Insert if the plan uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i><br><br><Days and hours of operation> |
| <b>FAX</b>     | <i>[Fax number is optional.]</i>                                                                                                                                                                                                                                      |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                                                                     |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                                   |
| <b>WEBSITE</b> | <i>[Web URL.]</i>                                                                                                                                                                                                                                                     |

Contact Member Services to get help with:

- Questions about the plan
- Questions about claims or billing

*[If plans have different numbers for the functions listed below, plans should insert separate charts with the additional contact information.]*

- Coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of your *Member Handbook* or contact Member Services.
- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (refer to **Section F** *[insert reference, as applicable]*).
  - You can call us and explain your complaint at <phone number>.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above *[insert reference, as applicable]*).
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - *[Insert additional instructions regarding how to make a complaint as directed by the state.]*
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Member Handbook*.
- Coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**
    - the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs *[insert if applicable, and name of Medicaid program prescription drugs and over-the-counter drugs]*.
  - For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.

**Commented [ES1]:** Should this say the call is free and give the TTY number as well?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above *[insert reference, as applicable]*.)
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Payment for health care or drugs you already paid for

*[Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]*

  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of your *Member Handbook*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your *Member Handbook*.

**Commented [ES2]:** Should this say the call is free and give the TTY number as well?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B. Your Care Coordinator

*[Plans should include information explaining what a care coordinator is, how members can get a care coordinator, how they can contact the care coordinator, and how they can change their care coordinator. Plans can modify this section as appropriate.]*

|                |                                                                                                                                                                                                                                                                                                          |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <Phone number(s)> This call is free.<br><br><Days and hours of operation> <i>[Include information on the use of alternative technologies.]</i><br><br>We have free interpreter services for people who do not speak English.                                                                             |
| <b>TTY</b>     | <TTY phone number> This call is <i>[insert if applicable: not]</i> free.<br><br><i>[Insert if the plan uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i><br><br><Days and hours of operation> |
| <b>FAX</b>     | <i>[Fax number is optional.]</i>                                                                                                                                                                                                                                                                         |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                                                                                                        |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                                                                      |
| <b>WEBSITE</b> | <i>[Web address is optional.]</i>                                                                                                                                                                                                                                                                        |

Contact your care coordinator to get help with:

- Questions about your health care
- Questions about getting behavioral health (mental health and substance use disorder) services
- Questions about transportation
- Questions about long-term services and supports (LTSS). LTSS includes *[Plans should insert information describing LTSS coverage.]*
- *[Plans may insert bullets noting additional areas that care coordinators can provide assistance with.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### C. *[Insert State-specific Name of SHIP Program]*

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In *<insert state>*, the SHIP is called *<State-specific SHIP name>*.

*<Insert state-specific SHIP name>* is not connected with any insurance company or health plan.

|         |                                                                                                                                                                                                                               |
|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CALL    | <i>&lt;Phone number(s)&gt;</i><br><i>&lt;Days and hours of operation&gt;</i>                                                                                                                                                  |
| TTY     | <i>[TTY phone number is optional.]</i><br><i>[Insert if the SHIP uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| WRITE   | <i>&lt;Mailing address&gt;</i>                                                                                                                                                                                                |
| EMAIL   | <i>[Email address is optional.]</i>                                                                                                                                                                                           |
| WEBSITE | <i>&lt;Web address&gt;</i>                                                                                                                                                                                                    |

Contact *<insert name of SHIP program>* for help with:

- Questions about Medicare
- *<State-specific SHIP name>* counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.



**If you have questions**, please call *<plan name>* at *<toll-free phone and TTY numbers>*, *<days and hours of operation>*. The call is free. **For more information**, visit *<web address>*.

## D. Quality Improvement Organization (QIO)

Our state has an organization called <State-specific QIO name>. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. <State-specific QIO name> is not connected with our plan.

|                |                                                                                                                                                                                                                              |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <Phone number(s)>                                                                                                                                                                                                            |
| <b>TTY</b>     | <i>[TTY phone number is optional.]</i><br><i>[Insert if the QIO uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                            |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                          |
| <b>WEBSITE</b> | <Web address>                                                                                                                                                                                                                |

Contact <State-specific QIO name> for help with:

- Questions about your health care rights
- Making a complaint about the care you got if you:
  - have a problem with the quality of care,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## E. 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, or CMS.

|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free, 24 hours a day, 7 days a week.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>TTY</b>     | 1-877-486-2048 This call is free.<br>This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>WEBSITE</b> | <a href="https://www.medicare.gov">medicare.gov</a><br>This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices.<br>It includes helpful websites and phone numbers. It also has documents you can print right from your computer.<br>If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you. |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**F. *[Insert name of Medicaid Program]***

*[Plans must adapt this generic discussion of Medicaid to reflect the name or features of the Medicaid program in the plan's state or states.]*

*[If there are two different agencies handling eligibility and coverage/services, the plan should include both and clarify the role of each.]*

*[Plans must, as appropriate, include additional telephone numbers for Medicaid program assistance.]*

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call <State-specific Medicaid agency>.

*[If applicable, plans may also inform members that they can get information about Medicaid from county resource centers and indicate where members can find contact information for these centers.]*

|                |                                                                                                                                                                                                                                                          |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <i>[Insert state-specific Medicaid agency]</i><br><Days and hours of operation>                                                                                                                                                                          |
| <b>TTY</b>     | <i>[Insert number, if available. Or delete this row.] [Insert if the state Medicaid program uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| <b>WRITE</b>   | <Insert Mailing address>                                                                                                                                                                                                                                 |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                      |
| <b>WEBSITE</b> | <a href="http://www.healthcareoptions.dhcs.ca.gov/">www.healthcareoptions.dhcs.ca.gov/</a><br><Insert Web URL>                                                                                                                                           |

**Commented [ES3]:** I believe this is a web link for Medi-Cal and should not be included here.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## G. *[Insert State-specific name for ombudsman program]*

The *<State-specific name for ombudsman program>* works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. *<State-specific name for ombudsman program>* also helps you with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

|                |                                                                                                                                                                                                                                                       |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <p>&lt;Phone number(s)&gt;</p> <p>&lt;Days and hours of operation&gt;</p>                                                                                                                                                                             |
| <b>TTY</b>     | <p><i>[TTY phone number is optional.]</i></p> <p><i>[Insert if the ombudsman program uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i></p> |
| <b>WRITE</b>   | <Insert Mailing address>                                                                                                                                                                                                                              |
| <b>EMAIL</b>   | <p><i>[Email address is optional.]</i></p> <p><a href="mailto:">mailto:</a></p>                                                                                                                                                                       |
| <b>WEBSITE</b> | <p>&lt;Insert Web URL&gt;</p> <p><a href="http://www.dhcs.ca.gov/services/med-cal/Pages/MMCDOfficeoftheOmbudsman.aspx">www.dhcs.ca.gov/services/med-cal/Pages/MMCDOfficeoftheOmbudsman.aspx</a></p>                                                   |

**Commented [ES4]:** I believe this is a web link for Medi-Cal and should not be included here.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H. Programs to Help People Pay for Their Prescription Drugs

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

### H1. Extra Help

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything to get this “Extra Help.”

|                |                                                                                                                                                                       |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free, 24 hours a day, 7 days a week.                                                                      |
| <b>TTY</b>     | 1-877-486-2048 This call is free.<br>This number is for people who have difficulty with hearing or speaking.<br>You must have special telephone equipment to call it. |
| <b>WEBSITE</b> | <a href="https://www.medicare.gov">medicare.gov</a>                                                                                                                   |

*[Plans that have no drug cost sharing may delete this section.]*

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your correct copayment level, or if you already have the evidence, to provide this evidence to us.

- [Plans should insert process for allowing members to request assistance with obtaining best available evidence, and for providing this evidence.]*
- [Plans should update this description to accurately reflect the process in this bullet.]* When we receive the evidence showing your copayment level, we will update our system so that you will be charged the correct copayment when you get your next prescription. If you overpay your copayment, we will pay you back. Either we will send a check to you or we will deduct the amount from future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owned by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H2. State Pharmaceutical Assistance Program (SPAP) *[Plans in states without an SPAP or where the SPAP excludes enrollment of dual eligible individuals should delete this section.]*

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Medicare Part D drugs (other than “Extra Help” you still get the 70 percent discount on covered brand name drugs. Also, the plan pays five percent of the cost of brand drugs in the coverage gap. The 70 percent discount and the five percent paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

## H3. AIDS Drug Assistance Program (ADAP)

*[Plans should delete this section if not applicable.]* The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance *[insert state-specific ADAP information.]* Note: to be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of the State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance For information on eligibility criteria, covered drugs, or how to enroll in the program, please call *[insert state-specific ADAP contact information.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## I. Social Security

Social Security determines eligibility and handles enrollment for Medicare. U.S Citizens and lawful permanent residents who are 65 and older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

|                |                                                                                                                                                                                                                                  |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-772-1213<br>Calls to this number are free.<br>Available 8:00 am to 7:00 pm, Monday through Friday.<br>You can use their automated telephone services to get recorded information and conduct some business 24 hours a day. |
| <b>TTY</b>     | 1-800-325-0778<br>This number is for people who difficulty with hearing or speaking. You must have special telephone equipment to call it.                                                                                       |
| <b>WRITE</b>   | <Insert Mailing address>                                                                                                                                                                                                         |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i><br><a href="mailto:">mailto:</a>                                                                                                                                                             |
| <b>WEBSITE</b> | <a href="http://www.ssa.gov">www.ssa.gov</a>                                                                                                                                                                                     |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## J. Other resources

*[Plans may insert this section to provide additional information resources, such as county aging and disability resource centers, choice counselors, or area agencies on aging or any other sections as directed by the state. Plans should format consistently with other sections, include a brief description and information about any other resources they add, and update the Table of Contents.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 3: Using our plan’s coverage for your health care and other covered services

---

### Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you are billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number as appropriate. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Information about services and providers

**Services** are health care, long-term services and supports, supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and long-term services and supports (LTSS) are in **Chapter 4** of your *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of your *Member Handbook*.

**Providers** are doctors, nurses, and other people who give you services and care. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain long-term services and supports (LTSS).

**Network providers** are providers who work with our plan. These providers agree to accept our payment *[insert if plan has cost sharing: and your cost sharing amount]* as full payment. *[Plans may delete the next sentence if it is not applicable.]* Network providers bill us directly for care they give you. When you use a network provider, you usually pay *[insert as applicable: nothing or only your share of the cost]* for covered services.

---

## B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and *[Insert name of state-specific Medicaid program]*. This includes behavioral health and long-term services and supports (LTSS).

Our plan will generally pay for health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be a **plan benefit**. This means we include it in our Benefits Chart in **Chapter 4** of your *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise the state-specific definition of "medically necessary" as appropriate and ensure that it is updated and used consistently throughout member material models.]*
- *[Plans may omit or edit the PCP-related bullets as necessary, including modifying the name of the PCP.]* For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another doctor. As a plan member, you must choose a network provider to be your PCP.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- In most cases, *[insert as applicable: your network PCP or our plan]* must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services. To learn more about referrals, refer to page <page number>.
- *[Insert if applicable: Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is [insert definition].]*
- You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, refer to section D1 in this chapter).
- **You must get your care from network providers** *[insert if applicable: that are affiliated with your PCP's medical group]*. Usually, we won't cover care from a provider who doesn't work with our health plan *[insert if applicable: and your PCP's medical group]*. This means that you will have to pay the provider in full for the services furnished. Here are some cases when this rule does not apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to section H in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. *[Plans may specify whether authorization should be obtained before seeking care.]* In this situation, we cover the care *[insert as applicable: as if you got it from a network provider or at no cost to you]*.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility. *[Insert as applicable: The cost sharing you pay for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from an out-of-network provider the cost sharing for the dialysis may be higher.]*

*[Plans add additional exceptions as appropriate including exceptions as required by the state.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## C. Your care coordinator

*[Plans provide applicable information about the care coordinator and care coordination, as well as explanations for the following subsections. Plans should replace the terms “care coordinator” and “care team” with terms they use. If Plans use more than one type of “care coordinator,” multiple descriptions can be provided that describe each type, or additional language can be added to the care coordinator definition below.]*

### C1. What a care coordinator is

*[Example text: A care coordinator is a trained person who works for our plan to provide care coordination services for you.]*

### C2. How you can contact your care coordinator

### C3. How you can change your care coordinator

---

## D. Care from providers

### D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care. *[Insert if applicable: Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group.]*

#### Definition of a PCP and what a PCP does do for you

*[Plans describe the following in the context of their plans:]*

What a PCP is

If applicable, what a medical group or IPA is

What types of providers may act as a PCP *[If a State allows specialists to act as a PCP, plans must inform members of this and under what circumstances a specialist may be a PCP.]*

The role of a PCP in

- Coordinating covered services
- Making decisions about or getting prior authorization (PA), if applicable

When a clinic can be your PCP (RHC/FQHC)]

#### Your choice of PCP



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans describe how to choose a PCP. Plans that assign members to medical groups or IPAs must include language that explains how the choice of PCP will affect member access to specialists and hospitals. For example:*

*If there is a particular specialist or hospital that you want to use, find out if they're affiliated with your PCP's medical group. You can look in the [Provider and Pharmacy Directory](#), or ask Member Services to find out if the PCP you want makes referrals to that specialist or uses that hospital.]*

### Option to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

*[Plans describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.).]*

*[Insert if applicable: Our plan's PCPs are affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for a change, tell Member Services if you use a specialist or get other covered services that must have PCP approval. Member Services helps you continue your specialty care and other services when you change your PCP.]*

### Services you can get without approval from your PCP

*[Note: Insert this section only if plans require referrals to network providers.]*

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to a network provider (for example, if you're outside our plan's service area or during the weekend).

**Note:** Urgently needed care must be immediately needed and medically necessary.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccinations *[insert if applicable: as well as hepatitis B vaccinations and pneumonia vaccinations]* *[insert if applicable: as long as you get them from a network provider]*.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams *[insert if applicable: as long as you get them from a network provider]*.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.

*[Plans add additional bullets consistently formatted like the rest of this section as appropriate.]*

## D2. Care from specialists and other network providers

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

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

*[Plans describe how members access specialists and other network providers, including:*

*The role (if any) of the PCP in referring members to specialists and other providers.*

*A description of PA as well as the process for getting PA [Plans explain that PA means the member gets plan approval before getting a specific service or drug or using an out-of-network provider, and plans include information about who makes the PA decision (e.g., Medical Director, the PCP, or another entity).] Refer members to Chapter 4 for information about which services require PA.*

*If PCP selection results in being limited to specific specialists or hospitals to which that PCP refers [For example, plans include information about subnetworks.]]*

*[Plans with referral models, insert: A written referral may be for one visit or it may be a standing referral for more than one visit if you need ongoing services. We must give you a standing referral to a qualified specialist for any of these conditions:*

- A chronic (ongoing) condition;



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- A life-threatening mental or physical illness;
- A degenerative disease or disability;
- Any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a written referral when needed, the bill may not be paid. For more information, call Member Services at the number at the bottom of this page.]

*[Plans with direct access models, insert: If we are unable to find you a qualified plan network provider, we must give you a standing service authorization for a qualified specialist for any of these conditions:*

- A chronic (ongoing) condition;
- A life-threatening mental or physical illness;
- A degenerative disease or disability;
- Any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a service authorization from us when needed, the bill may not be paid. For more information, call Member Services at the phone number printed at the bottom of this page.]

### D3. When a provider leaves our plan

*[Plans may edit this section if Medicaid requires them to have a transition benefit when a provider leaves the plan.]*

A network provider you use may leave our plan. If one of your providers leaves our plan, you have certain rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we work with you to ensure, that the medically necessary treatment you are getting is not interrupted.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to Chapter 9 *[plans may insert reference, as applicable]* for more information.)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. *[Plans include contact information for assistance.]*

#### D4. Out-of-network providers

*[Plans tell members under what circumstances they can get services from out-of-network providers (e.g., when providers of specialized services are not available in network). Include Medicaid out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it.] [Note: members are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover dialysis services for ESRD members who have traveled outside the plans service area or when the provider is temporarily unavailable or not accessible and are not able to access contracted ESRD providers.]*

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or *[Insert name of state-specific Medicaid program]*.

- We cannot pay a provider who is not eligible to participate in Medicare and/or *[Insert name of state-specific Medicaid program]*.
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

---

#### E. Long-term services and supports (LTSS)

*[Plans should provide applicable information about getting LTSS.]*

---

#### F. Behavioral health (mental health and substance use disorder) services

*[Plans should provide applicable information about getting behavioral health services.]*

---

#### G. *[If applicable plans should add: How to get self-directed care]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans should provide applicable information about getting self-directed care, including the following subsections.]*

**G1. What self-directed care is**

**G2. Who can get self-directed care (for example, if it is limited to waiver populations)**

**G3. How to get help in employing personal care providers (if applicable)**

---

**H. Transportation services**

*[Plans should provide applicable information about getting transportation services.]*

---

**I. Covered services in a medical emergency, when urgently needed, or during a disaster**

**I1. Care in a medical emergency**

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- Serious risk to your health *[insert as applicable: or to that of your unborn child];*  
**or**
- Serious harm to bodily functions; **or**
- Serious dysfunction of any bodily organ or part; **or**
- *[Insert as applicable: In the case of a pregnant woman in active labor, when:*
  - there is not enough time to safely transfer you to another hospital before delivery.
  - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



territories *[insert as applicable: or worldwide]*, from any provider with an appropriate state license.

- *[Plans add if applicable: As soon as possible, tell our plan about your emergency. We follow up on your emergency care. You or someone else [plans may replace "someone else" with "your care coordinator" or other applicable term] should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us.] [Plans must provide the contact phone number and days and hours of operation or explain where to find the information (e.g., on the back of the Member ID Card).]*

### Covered services in a medical emergency

*[Plans that cover emergency medical care outside the United States or its territories through Medicaid may describe this coverage based on the Medicaid program coverage area. Plans must also include language emphasizing that Medicare does not provide coverage for emergency medical care outside the United States and its territories.]*

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

*[Plans may add to this paragraph as needed to include other information about their post-stabilization care.]* Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

### Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

After the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## 12. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need treatment.

### Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it is not possible or reasonable to get to a network provider, we cover urgently needed care you get from an out-of-network provider.

*[Plans must insert instructions for how to access urgently needed services (e.g., using urgent care centers, a provider hotline, etc.).]*

### Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider.

*[Plans that cover urgently needed care outside the United States or its territories through Medicaid may describe this coverage based on the Medicaid program coverage area.]*

Our plan does not cover urgently needed care or any other *[insert if plan covers emergency care outside of the United States and its territories: non-emergency]* care that you get outside the United States.

*[Insert if applicable: Plans with world-wide emergency/urgent coverage as a supplemental benefit: Our plan covers worldwide [insert as applicable: emergency and urgently needed care OR emergency OR urgently needed care] services outside the United States under the following circumstances [insert details.]]*

## 13. Care during a disaster

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

Visit our website for information on how to get care you need during a declared disaster: <web address>. *[In accordance with 42 CFR 422.100(m), plans must include on their web page, at a minimum, information about coverage of benefits at non-contracted facilities at network cost sharing without required PA; terms and conditions of payment for non-contracted providers; and each declared disaster's start and end dates.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at *[insert as applicable: the in-network cost-sharing rate or no cost to you]*. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of your *Member Handbook* for more information.

---

## J. What to do if you are billed directly for services our plan covers

*[Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]*

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay *[plans with cost sharing, insert: our share of]* the bill.

**You should not pay the bill yourself. If you do, we may not be able to pay you back.**

*[Insert as applicable: If you paid for your covered services or If you paid more than your plan cost-sharing for covered services]* or if you got a bill for *[plans with cost sharing, insert: the full cost of]* covered medical services, refer to **Chapter 7** of your *Member Handbook* to find out what to do.

### J1. What to do if our plan does not cover services

*[Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]*

Our plan covers all services:

- That are determined medically necessary, **and**
- That are listed in our plan's Benefits Chart (refer to **Chapter 4** of your *Member Handbook*), **and**
- That you get by following plan rules.

If you get services that our plan does not cover, **you pay the full cost yourself.**

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

**Chapter 9** of your *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We pay for some services up to a certain limit. If you use over the limit, you pay the full cost to get more of that type of service. Refer to Chapter 4 for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

---

## K. Coverage of health care services in a clinical research study

### K1. Definition of a clinical research study

*[If applicable, plans revise this section to describe Medicaid role in providing coverage and payment for clinical research studies.]*

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare *[plans that conduct or cover clinical trials that are not approved by Medicare, insert: or our plan]* approves a study you want to be in, and you express interest, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

While you're in the study, you may stay enrolled in our plan. That way, our plan continues to cover you for services and care not related to the study.

If you want to take part in any Medicare-approved clinical research study, you do **not** need to tell us or get approval from us *[plans that do not use PCPs may delete the rest of this sentence]* or your primary care provider. Providers that give you care as part of the study do **not** need to be network providers.

#### **We encourage you to tell us before you take part in a clinical research study.**

If you plan to be in a clinical research study, you or your care coordinator should contact Member Services to let us know you will take part in a clinical trial.

### K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- 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 that is part of the research study.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Treatment of any side effects and complications of the new care.

*[Plans that conduct or cover clinical trials that are not approved by Medicare insert: If you volunteer for a clinical research study, we pay any costs that Medicare does not approve but that our plan approves.]* If you're part of a study that Medicare *[plans that conduct or cover clinical trials that are not approved by Medicare, insert: or our plan]* has **not** approved, you pay any costs for being in the study.

### K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website ([www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf](http://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf)). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

---

## L. How your health care services are covered in a religious non-medical health care institution

### L1. Definition of a religious non-medical health care institution

*[If applicable, plans revise this section to describe Medicaid's role in providing care in religious non-medical health care institutions.]*

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

### L2. Care from a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you get services from this institution that are provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - *[Omit this bullet if not applicable]* You must get approval from us before you are admitted to the facility, or your stay will **not** be covered.

*[Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Benefits Chart in Chapter 4 *[insert reference, as applicable]*) or whether there is unlimited coverage for this benefit.]*

## M. Durable medical equipment (DME)

### M1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own certain items, such as prosthetics.

In this section, we discuss DME *you rent*. As a member of our plan, you *[insert if the plan sometimes allows transfer of ownership to the member: usually]* will **not** own DME, no matter how long you rent it.

*[If the plan allows transfer of ownership of certain DME items to members, the plan must modify this section to explain the conditions and when the member can own specified DME.]*

*[If the plan sometimes allows transfer of ownership to the member for DME items other than prosthetics, insert: In certain limited situations, we transfer ownership of the DME item to you. Call Member Services to find out about requirements you must meet and papers you need to provide.]*

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you will **not** own the equipment.

*[Plans should modify this section as necessary to explain any additional Medicaid coverage of DME.]*

### M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

**Commented [ES1]:** Would it be possible to add optional language here to indicate that it's the plan that rents the equipment for the member for plans that don't have member copays?

**Commented [ES2]:** If members do not make payments for DME under the plan because of Medicaid coverage, then **all** of this section can be modified to make it clear that the plan rather than the member is paying, correct?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Note:** You can find definitions of Original Medicare and MA Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2023* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you)) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Commented [BJ3]: 2024

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments do not count toward the payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan

### M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you're a member of our plan, we cover:

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

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

### M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- Oxygen equipment, supplies, and services for another 24 months.
- Oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.





## Chapter 4: Benefits chart

### Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services *[insert if the plan has cost sharing: and how much you pay for each service]*. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

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**If you have questions**, please call <plan name> at <toll-free phone and TTY/TDD numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 1

## A. Your covered services *[insert if the plan has cost sharing: and your out-of-pocket costs]*

This chapter tells you about services our plan covers *[insert if the plan has cost-sharing: and how much you pay for each service]*. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your *Member Handbook*. *[Insert if applicable: This chapter also explains limits on some services.]*

*[Plans with cost sharing, insert: For some services, are charged an out-of-pocket cost called a copay. This is a fixed amount (for example, \$5) you pay each time you get that service. You pay the copay at the time you get the medical service.]*

*[Plans with **no** cost-sharing for any services described in this chapter, insert: Because you get assistance from *[Insert name of state-specific Medicaid program]*, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of your *Member Handbook* for details about the plan's rules.]*

If you need help understanding what services are covered, call *[insert: your care coordinator and/or Member Services at <phone number(s)>]*.

*[As applicable, plans insert the subsection heading and information below.]*

### A1. During public health emergencies

*[Plans providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describe the coverage and flexibilities here or include general information about the coverage and flexibilities along with any cross references, as applicable. Plans include whether such coverage and flexibilities are contingent upon the duration of the public health emergency, which may or may not last for the entire year. Plans also include any specific contact information, as applicable, where members can get more details.]*

**Commented [ES1]:** Because some D-SNP members do have copays for Part D drugs (which are not described in this chapter) it might help to specify "covered **medical** services" here just to make it clear that we are not referring to absolutely everything. And maybe even add a sentence to this paragraph that tells them which chapter to go to for info about Part D drug costs.

## B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

**You should never get a bill from a provider for covered services.** If you do, refer to **Chapter 7** of your *Member Handbook* or call Member Services.

## C. About our plan's Benefits Chart



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans may add references to long-term care or home and community-based services.]*

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them. *[Plans that include an index at the end of the chapter should insert: To find a service in the chart, you can also use the index at the end of the chapter.]*

**We pay for the services listed in the Benefits Chart when the following rules are met.**

*[Plans that do not have cost-sharing, insert: You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.]*

- We provide covered Medicare and *[Insert name of state-specific Medicaid program]* covered services according to the rules set by Medicare and *[Insert name of state-specific Medicaid program]*.
- The services *[Plans may revise as applicable: (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs)]* must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise and use the state-specific definition of “medically necessary” and ensure that it is updated and used consistently in Chapter 12 and throughout member materials.]*
- *[Insert if applicable: You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care* **or unless your plan or a network provider has given you a referral.** *Chapter 3 of your Member Handbook has more information about using network and out-of-network providers.]*
- *[Insert if applicable: You have a primary care provider (PCP) or a care team that is providing and managing your care. [Plans that do not require referrals, omit the rest of this paragraph:]* In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan’s network. This is called a referral. **Chapter 3** of your *Member Handbook* has more information about getting a referral and when you do **not** need one.]
- *[Insert if applicable: We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need prior authorization (PA) [insert as appropriate: with an asterisk (\*)* **or** *with a*

**Commented [ES2]:** The wording here is problematic because it isn't a *referral* that's needed to see an out-of-network provider, it's an *authorization*. The plan (not the provider) can give a member an authorization to see an out-of-network provider. Referrals are different and some plans are direct access plans and do not require referrals to see specialists, etc.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

footnote **or** in bold type *or* in italic type.].] *[Insert if applicable: In addition, you must get prior authorization (PA) for the following services not listed in the Benefits Chart: [insert list].]*

- *[Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI)” in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Members with Certain Chronic Conditions**. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [insert if applicable: and/or reduced cost sharing]:*
  - *[List all applicable chronic conditions here.]*
  - *[If offering SSBCI, include information about the process and/or criteria for determining eligibility for SSBCI. Plan must also deliver a written summary of the SSBCI offered to each chronically ill member eligible for SSBCI.]*

Refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.]

- *[Insert as applicable: Most **or** All]* preventive services are free. You find this apple  next to preventive services in the Benefits Chart.
- *[Insert any additional applicable Medicaid program coverage here such as community supports]*

*[Instructions on completing the Benefits Chart:*

- *For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.*
- *Optional supplemental benefits are not permitted in this chart; optional supplemental benefits should be described in section E.*
- *Include the following where appropriate: Talk to your provider and get a referral.*
- *Plans must include any services provided in excess of the Medicare and Medicaid requirements and identify preventive services with the apple icon.*
- *HMO POS plan types must provide information about which services must be obtained from network providers, which services can be obtained out-of-network under the POS benefit, and any differences in cost sharing for covered services obtained out-of-network under the POS benefit.*

**Commented [ES3]:** Would it be possible to move the list of chronic conditions into the actual Benefits Chart? It seems odd to have that information here, and then in the chart, plans have to refer them *back* to this page to see what conditions are eligible.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Plans should clearly indicate which benefits are subject to prior authorization (PA). (This can be done with asterisks, footnotes, bold type, or italic type. Plans must select only one method of indication, describe it in terms easily understandable by members, make the indication and description prominently visible, and use it consistently throughout the document.)*
- *Plans may insert any additional benefit information that is based on the plan's approved benefit package and not already included in the Benefits Chart or in the exclusions section. Plans insert any additional benefits in the chart alphabetically.*
- *Plans must add any Medicaid benefits covered to the chart as instructed by the state. Insert any additional benefits in the chart alphabetically. If directed by the state, include all non-waiver services in the chart and all HCBS waiver services as a separate section after the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed. The remainder of the sections should then be renumbered.*
- *Plans must describe any restrictive policies, limitations, or monetary limits that might affect a member's access to services within the chart.*
- *Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.*
- *Plans should include all non-waiver LTSS in the chart in alphabetical order.*
- *Plans with no cost sharing for any type of service (i.e., no cost sharing at all) may delete the "what you must pay" column from the table. Plans with any type of cost sharing for services, including for pharmacy services, must leave the "what you must pay" column in the table.*
- *Plans offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:*
  - *Deliver to each clinically-targeted member a written summary of those benefits so that such member are notified of the "Uniformity Flexibility" benefits for which they are eligible.*
  - *Update the Benefits Chart to include details, as applicable, about the exact targeted reduced cost sharing amount for each specific service and/or the additional supplemental benefits being offered.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

D. Our plan’s Benefits Chart

*[When a benefit continues from one page to the next, plans enter a blank return before right aligning and inserting at the bottom of the first part of the description: **This benefit is continued on the next page.** At the top of the next page where the benefit description continues, plans enter the benefit name again in bold followed by (continued). Plans may refer to **Durable medical equipment (DME) and related supplies** and other benefits later in this chart as examples. Plans should also be aware that the flow of benefits from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed.]*

*[Plans should modify this section throughout to reflect Medicaid or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medicaid.]*

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay                                               |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
|  | <p><b>Abdominal aortic aneurysm screening</b></p> <p>We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | What you must pay                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|
|  <b>Acupuncture</b><br>We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: <ul style="list-style-type: none"><li>• lasting 12 weeks or longer;</li><li>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);</li><li>• not associated with surgery; <b>and</b></li><li>• not associated with pregnancy.</li></ul> In addition, we pay for an <b>additional 8 sessions</b> of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.<br>Acupuncture treatments must be stopped if you don't get better or if you get worse.<br><i>[List any additional benefits offered.]</i> |  | \$0<br><i>[List copays for additional benefits.]</i> |
|  <b>Alcohol misuse screening and counseling</b><br>We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.<br>If you screen positive for alcohol misuse, you can get up to <b>four</b> brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                                                             |  | \$0                                                  |

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**Commented [ES4]:** In other places, numerals have been used even for numbers below 10 (e.g., see highlighted use of 8 under Acupuncture above). Would it be possible to do that here (use 4) and throughout to be consistent? Numerals, from a health literacy standpoint, are easier to read and comprehend for many people.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | What you must pay                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|
|  <b>Ambulance services</b><br><br>Covered ambulance services include ground, air (airplane and helicopter), and rotary-wing ambulance services. The ambulance will take you to the nearest place that can give you care.<br><br>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases must be approved by us.<br><br>In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. |  | \$0                                                               |
|  <b>Annual wellness visit</b><br><br>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                                                                                                                                                                                                                                                  |  | \$0                                                               |
|  <b>Bone mass measurement</b><br><br>We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.<br><br>We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                          |  | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
|  <p><b>Breast cancer screening (mammograms)</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>One baseline mammogram between the ages of 35 and 39 <i>[plans that only cover ages 65 and older should delete]</i></li> <li>One screening mammogram every 12 months <i>[plans that cover women under 65 should include: for women age 40 and older]</i></li> <li>Clinical breast exams once every 24 months</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                    | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><b>Cardiac (heart) rehabilitation services</b></p> <p>We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's <i>[insert as appropriate: referral or order]</i>.</p> <p>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.</p>                                                                                                                                                                                                                                              | <p>\$0</p>                                                      |
|  <p><b>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</b></p> <p>We pay for one visit a year, or more if medically necessary, with your primary care provider to help lower your risk for heart disease. During the <i>[insert: visit or visits]</i>, your doctor may:</p> <ul style="list-style-type: none"> <li>Discuss aspirin use,</li> <li>Check your blood pressure, <b>and/or</b></li> <li>Give you tips to make sure you are eating well.</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                                        |
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|  <b>Cardiovascular (heart) disease testing</b><br>We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                         | \$0<br><i>[List copays for additional benefits.]</i>                     |
|  <b>Cervical and vaginal cancer screening</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>For all women: Pap tests and pelvic exams once every 24 months</li> <li>For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months</li> <li><i>[Plans that cover women under 65 must include: For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months]</i></li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><i>[List copays for additional benefits.]</i>                     |
| <b>Chiropractic services</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>Adjustments of the spine to correct alignment</li> </ul> <i>[List any Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.]</i>                                                                                                                                                                                                                                                                                                                         | <i>[List copays.]</i><br><i>[List copays for supplemental benefits.]</i> |

Commented [ES5]: 5



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay                                                               |
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|  <b>Colorectal cancer screening</b><br>For people <b>50</b> and older, we pay for the following services: <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema) every 48 months</li> <li>• Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months</li> <li>• DNA based colorectal screening, every 3 years</li> <li>• Screening Colonoscopy every <b>ten</b> years (but not within 48 months of a screening sigmoidoscopy)</li> <li>• Screening Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months.</li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><i>[List copays for additional benefits.]</i>                            |
| <i>[Include row if applicable and modify to accurately describe the Medicaid and/or supplemental benefit offered.]</i><br><b>Dental services</b><br>Certain dental services, including cleanings, fillings, and dentures, are available through the <i>[insert name of Medicaid program or integrated name]</i> Dental Program.<br><i>[Plans that offer optional supplemental dental benefits insert:</i><br><b>Note:</b> Our plan offers additional dental services. Got to Benefits Chart in <b>Section E</b> for more information. <i>]</i>                                                                                                                                                                                                                      | <i>[If plan offers supplemental benefit, the maximum copay amount is \$10.]</i> |
|  <b>Depression screening</b><br>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$0<br><i>[List copays for additional benefits.]</i>                            |

**Commented [ES6]:** The current recommendation is for people 45 and over. Can this be updated to be consistent with that?

**Commented [ES7]:** Could this be 10 instead of ten to be consistent?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                               |
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|  | <p><b>Diabetes screening</b></p> <p>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"><li>• High blood pressure (hypertension)</li><li>• History of abnormal cholesterol and triglyceride levels (dyslipidemia)</li><li>• Obesity</li><li>• History of high blood sugar (glucose)</li></ul> <p>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.</p> <p>Depending on the test results, you may qualify for up to <b>two</b> diabetes screenings every 12 months.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |

**Commented [ES8]:** Could this be 2 instead of two to be consistent?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | What you must pay                                               |
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| <div data-bbox="154 464 191 499"></div> <p><b>Diabetic self-management training, services, and supplies</b></p> <p>We pay for the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> <li>Supplies to monitor your blood glucose, including the following: <ul style="list-style-type: none"> <li>A blood glucose monitor</li> <li>Blood glucose test strips</li> <li>Lancet devices and lancets</li> <li>Glucose-control solutions for checking the accuracy of test strips and monitors</li> </ul> </li> <li>For people with diabetes who have severe diabetic foot disease, we pay for the following: <ul style="list-style-type: none"> <li>One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, <b>or</b></li> <li>One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)</li> </ul> </li> <li>In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |

Commented [ES9]: Suggest 2

Commented [ES10]: Suggest 3



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| <p><b>Durable medical equipment (DME) and related supplies</b></p> <p>Refer to Chapter 12 of your <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).”</p> <p>We cover the following items:</p> <ul style="list-style-type: none"> <li>• Wheelchairs</li> <li>• Crutches</li> <li>• Powered mattress systems</li> <li>• Diabetic supplies</li> <li>• Hospital beds ordered by a provider for use in the home</li> <li>• Intravenous (IV) infusion pumps and pole</li> <li>• Speech generating devices</li> <li>• Oxygen equipment and supplies</li> <li>• Nebulizers</li> <li>• Walkers</li> <li>• Standard curved handle or quad cane and replacement supplies</li> <li>• Cervical traction (over the door)</li> <li>• Bone stimulator</li> <li>• Dialysis care equipment</li> </ul> <p>Other items may be covered.</p> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays, including how they vary for equipment covered by Medicare and Medicaid, if applicable.]</i></p> <p><i>[Include if applicable: Your cost sharing for Medicare oxygen equipment coverage is [insert copay amount or coinsurance percentage], every [insert required frequency of payment].]</i></p> <p><i>[Plans that use a constant cost-sharing structure for oxygen equipment insert: Your cost sharing will not change after being enrolled for 36 months.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay                                                                                                                                                                                                                                                                                                                                                                              |
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| <p><b>Durable medical equipment (DME) and related supplies (continued)</b></p> <p><i>[Plans that do not limit the DME brands and manufacturers that they cover, insert: We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.]</i></p> <p><i>[Plans that limit the DME brands and manufacturers that they cover, insert the following (for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual): With this Member Handbook, we sent you our plan's list of DME. The list tells you the brands and makers of DME that we pay for. You may also find the most recent list of brands, makers, and suppliers on our website at &lt;URL&gt;.</i></p> <p>Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We do not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to our plan and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)</p> <p>If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor may file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is right for your medical condition. For more information about appeals, refer to <b>Chapter 9</b> of your <i>Member Handbook</i>.]</p> | <p><i>[Plans that wish to vary cost sharing for oxygen equipment after 36 months insert details including whether original cost sharing resumes after 5 years and you are still in the plan.] [If cost sharing is different for members who made 36 months of rental payments prior to joining the plan insert: If prior to enrolling in [insert plan name] is [insert cost sharing].]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                          |
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| <p><b>Emergency care</b></p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> <li>Given by a provider trained to give emergency services, <b>and</b></li> <li>Needed to treat a medical emergency.</li> </ul> <p>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> <li>Serious risk to your health <i>[Plans that cover women under 65 must include: or to that of your unborn child]; or</i></li> <li>Serious harm to bodily functions; <b>or</b></li> <li>Serious dysfunction of any bodily organ or part; <b>or</b></li> <li><i>[Plans that cover women under 65 must include: In the case of a pregnant woman in active labor, when:</i> <ul style="list-style-type: none"> <li>There is not enough time to safely transfer you to another hospital before delivery.</li> <li>A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]</li> </ul> </li> </ul> <p><i>[Also identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.]</i></p> | <p>\$0</p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, <i>[plans should insert information as needed to accurately describe emergency care benefits: (e.g., you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.)]</i>.</p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay            |
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| <p><i>[If family planning services are covered, plans should modify this as necessary.]</i></p> <p><b>Family planning services</b></p> <p>The law lets you choose any provider for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Family planning exam and medical treatment</li> <li>• Family planning lab and diagnostic tests</li> <li>• Family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring)</li> <li>• Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)</li> <li>• Counseling and diagnosis of infertility and related services</li> <li>• Counseling, testing, and treatment for sexually transmitted infections (STIs)</li> <li>• Counseling and testing for HIV and AIDS, and other HIV-related conditions</li> <li>• Permanent Contraception (You must be age 21 or older to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.)</li> <li>• Genetic counseling</li> </ul> <p>We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:</p> <ul style="list-style-type: none"> <li>• Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)</li> <li>• Treatment for AIDS and other HIV-related conditions</li> <li>• Genetic testing</li> </ul> | <p><i>[List copays.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                                      |
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|  <b>Health and wellness education programs</b><br><i>[These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness and stress management. Describe the nature of the programs here.]</i><br><i>[If this benefit is not applicable, plans should delete this row.]</i>                                                                                                                                                                                                             | <i>[List copays.]</i>                                                  |
| <i>[Plans should modify this section to reflect plan-covered benefits as appropriate.]</i><br><b>Hearing services</b><br>We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.                                                                                                                                                                                                                                                                                                                                                                | <i>[List copays.]</i><br><i>[List copays for additional benefits.]</i> |
| <i>[If this benefit is not applicable, plans should delete this row.]</i><br><b>Help with certain chronic conditions</b><br><i>[Plans that offer targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI),” which members with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits and (as applicable) reduced cost sharing. If offering SSBCI, plans must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package submission.]</i> | <i>[List copays.]</i>                                                  |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay                                    |
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|  <b>HIV screening</b><br>We pay for one HIV screening exam every 12 months for people who: <ul style="list-style-type: none"> <li>• Ask for an HIV screening test, <b>or</b></li> <li>• Are at increased risk for HIV infection.</li> </ul> For women who are pregnant, we pay for up to <b>three</b> HIV screening tests during a pregnancy.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                                                                                                                                                                             | \$0<br><i>[List copays for additional benefits.]</i> |
| <b>Home health agency care</b><br><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i><br>Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort.<br>We pay for the following services, and maybe other services not listed here: <ul style="list-style-type: none"> <li>• 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.)</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> </ul> | <i>[List copays.]</i>                                |

Commented [ES11]: Suggest 3



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                                                                   |
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| <p><b>Home infusion therapy</b></p> <p>Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:</p> <ul style="list-style-type: none"><li>• The drug or biological substance, such as an antiviral or immune globulin;</li><li>• Equipment, such as a pump; <b>and</b></li><li>• Supplies, such as tubing or a catheter.</li></ul> <p>Our plan covers home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"><li>• Professional services, including nursing services, provided in accordance with your care plan;</li><li>• Member training and education not already included in the DME benefit;</li><li>• Remote monitoring; <b>and</b></li><li>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.</li></ul> <p><a href="#">[List any additional benefits offered.]</a></p> | <p><a href="#">[List copays.]</a></p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                                                                                                    |
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| <p><b>Hospice care</b></p> <p>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have <u>six</u> months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Our plan pays for the following while you get hospice services:</p> <ul style="list-style-type: none"> <li>• Drugs to treat symptoms and pain</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul> <p><b>Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.</b></p> <ul style="list-style-type: none"> <li>• Refer to <b>Section F</b> of this chapter for more information.</li> </ul> <p><b>For services covered by our plan but not covered by Medicare Part A or Medicare Part B:</b></p> <ul style="list-style-type: none"> <li>• Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay <i>[insert as appropriate: our plan's cost-sharing amount or nothing]</i> for these services.</li> </ul> <p><b>For drugs that may be covered by our plan's Medicare Part D benefit:</b></p> <ul style="list-style-type: none"> <li>• Drugs are never covered by both hospice and our plan at the same time. For more information, refer to <b>Chapter 5</b> of your <i>Member Handbook</i>.</li> </ul> <p><b>Note:</b> If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that is <b>not</b> related to your terminal prognosis.</p> <p><i>[Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.]</i></p> | <p><i>[List copays.]</i></p> <p><i>[Include information about cost sharing for hospice consultation services if applicable.]</i></p> |

**Commented [ES12]:** Suggest 6

**Commented [BJ13]:** Hospice provider/Original Medicare pays for this:

Original Medicare will be billed for your hospice care, even if you're in a Medicare Advantage Plan. When you get hospice care, your Medicare Advantage Plan can still cover services that aren't a part of your terminal illness or any conditions related to your terminal illness.

Ch 4: An MA enrollee who elects hospice care, but chooses not to disenroll from the plan, is entitled to continue to receive through the plan any MA benefits other than those that are the responsibility of the hospice. Under such circumstances, the **MA** plan is paid a reduced capitation rate for that enrollee by CMS and the **MA plan** is responsible for continued coverage of supplemental benefits. CMS pays: (a) the hospice program for hospice care furnished to the enrollee and (b) the **MA plan**, providers, and suppliers for other Medicare-covered services furnished to the enrollee through the original Medicare program, subject to the usual rules of payment.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                                 |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
|  | <b>Immunizations</b><br><br>We pay for the following services: <ul style="list-style-type: none"><li>• Pneumonia vaccine</li><li>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary</li><li>• Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B</li><li>• COVID-19 vaccines</li><li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li></ul> We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to <b>Chapter 6</b> of your <i>Member Handbook</i> to learn more.<br><br><a href="#">[List any additional benefits offered.]</a> | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                    |
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| <p><b>Inpatient hospital care</b></p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p><i>[List any restrictions that apply.]</i></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units, such as intensive care or coronary care units</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Needed surgical and medical supplies</li> <li>• Appliances, such as wheelchairs</li> <li>• Operating and recovery room services</li> <li>• Physical, occupational, and speech therapy</li> <li>• Inpatient substance abuse services</li> <li>• In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><b>\$0</b></p> <p>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.</p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay |
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| <p><b>Inpatient hospital care (continued)</b></p> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. <i>[Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.]</i></p> <ul style="list-style-type: none"> <li>• Blood, including storage and administration</li> <li>• Physician services</li> </ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are you a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> |                   |
| <p><b>Inpatient services in a psychiatric hospital</b></p> <p>We pay for mental health care services that require a hospital stay. <i>[List days covered, restrictions such as 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.]</i></p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay |
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| <p><i>[Plans with no day limitations on a plan's hospital or nursing facility coverage may modify or delete this row as appropriate.]</i></p> <p><b>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</b></p> <p>We do not pay for your inpatient stay if it is not reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Doctor services</li> <li>• Diagnostic tests, like lab tests</li> <li>• X-ray, radium, and isotope therapy, including technician materials and services</li> <li>• Surgical dressings</li> <li>• Splints, casts, and other devices used for fractures and dislocations</li> <li>• Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: <ul style="list-style-type: none"> <li>○ An internal body organ (including contiguous tissue), <b>or</b></li> <li>○ The function of an inoperative or malfunctioning internal body organ.</li> </ul> </li> <li>• Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition</li> <li>• Physical therapy, speech therapy, and occupational therapy</li> </ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
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| <p><b>Kidney disease services and supplies</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to <b>six</b> sessions of kidney disease education services.</li><li>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in <b>Chapter 3</b> of your <i>Member Handbook</i>, or when your provider for this service is temporarily unavailable or inaccessible.</li><li>• Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care</li><li>• Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments</li><li>• Home dialysis equipment and supplies</li><li>• Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply.</li></ul> <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.</p> | \$0               |

Commented [ES14]: Suggest 6



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | What you must pay                                               |
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|  <p><b>Lung cancer screening</b></p> <p>Our plan pays for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> <li>• Are aged 50-77, <b>and</b></li> <li>• Have a counseling and shared decision-making visit with your doctor or other qualified provider, <b>and</b></li> <li>• Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.</li> </ul> <p>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.</p> <p><i>[Modify section to accurately describe benefits and list any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                         | <p>\$0</p>                                                      |
|  <p><b>Medical nutrition therapy</b></p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when <i>[insert as appropriate: referred or ordered]</i> by your doctor.</p> <p>We pay for <b>three</b> hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.</p> <p>We pay for <b>two</b> hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's <i>[insert as appropriate: referral or order]</i>. A doctor must prescribe these services and renew the <i>[insert as appropriate: referral or order]</i> each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |

**Commented [ES15]:** Suggest 3

**Commented [ES16]:** Suggest 2



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
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|  <p><b>Medicare Diabetes Prevention Program (MDPP)</b></p> <p>Our plans pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none"> <li>• Long-term dietary change, <b>and</b></li> <li>• Increased physical activity, <b>and</b></li> <li>• Ways to maintain weight loss and a healthy lifestyle.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$0               |
| <p><b>Medicare Part B prescription drugs</b></p> <p><i>[Plans that do or expect to use Medicare Part B step therapy should indicate the Medicare Part B drug categories below that are or may be subject to Medicare Part B step therapy as well as a link to a list of drugs subject to Medicare Part B step therapy. Plans may update the link throughout the year and add any changes at least 30 days prior to implementation per 42 CFR 422.111(d).]</i></p> <p>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs:</p> <ul style="list-style-type: none"> <li>• Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <li>• Osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> </ul> <p><b>This benefit is continued on the next page</b></p> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay |
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| <p><b>Medicare Part B prescription drugs (continued)</b></p> <ul style="list-style-type: none"> <li>Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents <i>[plans may delete any of the following drugs that they do not not cover]</i> (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</li> <li>IV immune globulin for the home treatment of primary immune deficiency diseases</li> </ul> <p><i>[Insert if applicable: The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: &lt;hyperlink&gt;.]</i></p> <p>We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit.</p> <p><b>Chapter 5</b> of your <i>Member Handbook</i> explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p><b>Chapter 6</b> of your <i>Member Handbook</i> explains what you pay for your outpatient prescription drugs through our plan.</p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay            |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate or eliminate this section if not covered.]</i></p> <p><b>Nursing facility care</b></p> <p>A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital.</p> <p>Services that we pay for include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Nursing services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Respiratory therapy</li> <li>• Drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)</li> <li>• Blood, including storage and administration</li> <li>• Medical and surgical supplies usually given by nursing facilities</li> <li>• Lab tests usually given by nursing facilities</li> <li>• X-rays and other radiology services usually given by nursing facilities</li> <li>• Use of appliances, such as wheelchairs usually given by nursing facilities</li> <li>• Physician/practitioner services</li> <li>• Durable medical equipment</li> <li>• Dental services, including dentures</li> <li>• Vision benefits</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                               |
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| <p><b>Nursing facility care (continued)</b></p> <ul style="list-style-type: none"> <li>• Hearing exams</li> <li>• Chiropractic care</li> <li>• Podiatry services</li> </ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> <li>• A nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care).</li> <li>• A nursing facility where your spouse or domestic partner is living at the time you leave the hospital.</li> </ul> |                                                                 |
| <p> <b>Obesity screening and therapy to keep weight down</b></p> <p>If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                         | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
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| <p><b>Opioid treatment program (OTP) services</b></p> <p>Our plan pays for the following services to treat opioid use disorder (OUD):</p> <ul style="list-style-type: none"> <li>• Intake activities</li> <li>• Periodic assessments</li> <li>• Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications</li> <li>• Substance use counseling</li> <li>• Individual and group therapy</li> <li>• Testing for drugs or chemicals in your body (toxicology testing)</li> </ul> <p><i>[List any other medically necessary treatment or additional benefits offered, with the exception of meals and transportation.]</i></p> | \$0               |
| <p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy, including technician materials and supplies</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts, and other devices used for fractures and dislocations</li> <li>• Lab tests</li> <li>• Blood, including storage and administration</li> <li>• Other outpatient diagnostic tests</li> </ul> <p><i>[Plans can include other covered tests as appropriate.]</i></p>                   | \$0               |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay                                               |
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| <p><b>Outpatient hospital services</b></p> <p>We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services <ul style="list-style-type: none"> <li>○ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.”</li> <li>○ Sometimes you can be in the hospital overnight and still be “outpatient.”</li> <li>○ You can get more information about being inpatient or outpatient in this fact sheet: <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a></li> </ul> </li> <li>• Labs and diagnostic tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies, such as splints and casts</li> <li>• Preventive screenings and services listed throughout the Benefits Chart</li> <li>• Some drugs that you can’t give yourself</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay                                               |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient mental health care</b></p> <p>We pay for mental health services provided by:</p> <ul style="list-style-type: none"> <li>• A state-licensed psychiatrist or doctor</li> <li>• A clinical psychologist</li> <li>• A clinical social worker</li> <li>• A clinical nurse specialist</li> <li>• A nurse practitioner</li> <li>• A physician assistant</li> <li>• Any other Medicare-qualified mental health care professional as allowed under applicable state laws</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient rehabilitation services</b></p> <p>We pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p>                                                                                                                                                                                                       | <p>\$0</p>                                                      |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay            |
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| <p><b>Outpatient substance abuse services</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Alcohol misuse screening and counseling</li> <li>• Treatment of drug abuse</li> <li>• Group or individual counseling by a qualified clinician</li> <li>• Subacute detoxification in a residential addiction program</li> <li>• Alcohol and/or drug services in an intensive outpatient treatment center</li> <li>• Extended-release Naltrexone (vivitrol) treatment</li> </ul> <p><i>[Modify this list accurately describe benefits offered or add any additional benefits offered.]</i></p>                                                                                        | <p><i>[List copays.]</i></p> |
| <p><b>Outpatient surgery</b></p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p>                   |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Partial hospitalization services</b></p> <p>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.</p> <p><i>[Network plans that do not have an in-network community mental health center may add: <b>Note:</b> Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.]</i></p> | <p>\$0</p>                   |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | What you must pay                                               |
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| <p><b>Physician/provider services, including doctor's office visits</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Medically necessary health care or surgery services given in places such as:</li><li>• Physician's office</li><li>• Certified ambulatory surgical center</li><li>• Hospital outpatient department</li><li>• Consultation, diagnosis, and treatment by a specialist</li><li>• Basic hearing and balance exams given by your <i>[insert as applicable: primary care provider or specialist]</i>, if your doctor orders them to find out whether you need treatment</li><li>• <i>[Insert if providing any additional telehealth benefits consistent with 42 CFR § 422.135 in the plan's approved Plan Benefit Package submission: Certain telehealth services, including [insert general description of covered additional telehealth benefits (i.e., the specific Medicare Part B service(s) the plan has identified as clinically appropriate for offering through electronic exchange when the provider is not in the same location as the member). Plans may refer members to their medical coverage policy here].]</i></li></ul> <p><b>This benefit is continued on the next page</b></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"><li>○ 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. <i>[Plans may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.]</i></li><li>○ <i>[List the available means of electronic exchange used for each Medicare Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.]</i></li><li>● <i>[Insert if the plan's service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act: Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare]</i></li><li>● Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home</li><li>● Telehealth services to diagnose, evaluate, or treat symptoms of a stroke</li><li>● Telehealth services for members with a substance use disorder or co-occurring mental health disorder</li></ul> <p><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> <li>○ You have an in-person visit within 6 months prior to your first telehealth visit</li> <li>○ You have an in-person visit every 12 months while receiving these telehealth services</li> <li>○ Exceptions can be made to the above for certain circumstances</li> </ul> </li> <li>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.</li> <li>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b> <ul style="list-style-type: none"> <li>○ you're not a new patient <b>and</b></li> <li>○ The check-in isn't related to an office visit in the past 7 days and</li> <li>○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> <li>• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours <b>if</b>: <ul style="list-style-type: none"> <li>○ you're not a new patient and</li> <li>○ The evaluation isn't related to an office visit in the past 7 days <b>and</b></li> <li>○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient</li> <li>• Second opinion <i>[insert if appropriate: by another network provider]</i> before surgery</li> <li>• Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> <li>○ Surgery of the jaw or related structures</li> <li>○ Setting fractures of the jaw or facial bones</li> <li>○ Pulling teeth before radiation treatments of neoplastic cancer</li> <li>○ Services that would be covered when provided by a physician</li> </ul> </li> </ul> <p><i>[List any additional benefits offered.]</i></p> |                                                                 |
| <p><b>Podiatry services</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)</li> <li>• Routine foot care for members with conditions affecting the legs, such as diabetes</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p> <b>Prostate cancer screening exams</b></p> <p><i>[Plans that cover men under age 65 must include: For men age 50 and older,]</i> we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> <li>• A digital rectal exam</li> <li>• A prostate specific antigen (PSA) test</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Prosthetic devices and related supplies</b></p> <p>Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> <li>• Colostomy bags and supplies related to colostomy care</li> <li>• Pacemakers</li> <li>• Braces</li> <li>• Prosthetic shoes</li> <li>• Artificial arms and legs</li> <li>• Breast prostheses (including a surgical brassiere after a mastectomy)</li> </ul> <p>We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.</p> <p><i>[Plans that pay for prosthetic dental devices, delete the following sentence:]</i> We will not pay for prosthetic dental devices.</p> | <p>\$0</p>                                                      |
| <p><b>Pulmonary rehabilitation services</b></p> <p>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have <i>[insert as appropriate: a referral or an order]</i> for pulmonary rehabilitation from the doctor or provider treating the COPD.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.



| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay                                                        |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
|  | <p><b>Sexually transmitted infections (STIs) screening and counseling</b></p> <p>We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered <a href="#">[plans that cover women under age 65 should include: for pregnant women and]</a> for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also pay for up to <b>two</b> face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.</p> <p><a href="#">[Also list any additional benefits offered.]</a></p> | <p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p> |

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | What you must pay |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Skilled nursing facility (SNF) care</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"><li>• A semi-private room, or a private room if it is medically necessary</li><li>• Meals, including special diets</li><li>• Nursing services</li><li>• Physical therapy, occupational therapy, and speech therapy</li><li>• Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors</li><li>• Blood, including storage and administration</li><li>• Medical and surgical supplies given by nursing facilities</li><li>• Lab tests given by nursing facilities</li><li>• X-rays and other radiology services given by nursing facilities</li><li>• Appliances, such as wheelchairs, usually given by nursing facilities</li><li>• Physician/provider services</li></ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"><li>• A nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)</li><li>• A nursing facility where your spouse or domestic partner lives at the time you leave the hospital</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| <div> <b>Smoking and tobacco use cessation</b></div> <p>If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit:</p> <ul style="list-style-type: none"><li>We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.</li></ul> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</p> <ul style="list-style-type: none"><li>We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</li></ul> <p>[List any additional benefits offered.]</p> | <p>\$0</p> <p>[List copays for supplemental benefits.]</p> |

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Supervised exercise therapy (SET)</b></p> <p>We pay for SET for members with symptomatic peripheral artery disease (PAD) <i>[insert if applicable: who have a referral for PAD from the physician responsible for PAD treatment]</i>.</p> <p>Our plan pays for:</p> <ul style="list-style-type: none"><li>• Up to 36 sessions during a 12-week period if all SET requirements are met</li><li>• An additional 36 sessions over time if deemed medically necessary by a health care provider</li></ul> <p>The SET program must be:</p> <ul style="list-style-type: none"><li>• 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)</li><li>• In a hospital outpatient setting or in a physician's office</li><li>• Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD</li><li>• Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Urgently needed care</b></p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"><li>• A non-emergency that requires immediate medical care, <b>or</b></li><li>• A sudden medical illness, <b>or</b></li><li>• An injury, <b>or</b></li><li>• A condition that needs care right away.</li></ul> <p>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or during the weekend).</p> <p><i>[Include in-network benefits. Also identify whether this coverage is within the U.S. and its territories or is supplemental world-wide emergency/urgent coverage.]</i></p> | <p>\$0</p>        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | What you must pay                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
|  <p><i>[Plans should modify this section to reflect Medicaid and plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]</i></p> <p><b>Vision care</b></p> <p>We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.</p> <p>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> <li>• People with a family history of glaucoma</li> <li>• People with diabetes</li> <li>• African-Americans <i>[plans that cover under 65 must include: who are age 50 and older]</i></li> <li>• Hispanic Americans <i>[plans that cover under 65 must include: who are 65 or older]</i></li> </ul> <p><i>[Plans should modify this description if the plan offers more than is covered by Medicare.]</i> We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.</p> <p>If you have <b>two</b> separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get <b>two</b> pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.</p> | <p><i>[List copays.]</i></p> <p><i>[List copays for additional benefits.]</i></p> |

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- Commented [ES23]: Suggest 2



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
|  <p><b>“Welcome to Medicare” preventive visit</b></p> <p>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> <li>• A review of your health,</li> <li>• Education and counseling about the preventive services you need (including screenings and shots), <b>and</b></li> <li>• Referrals for other care if you need it.</li> </ul> <p><b>Note:</b> We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.</p> | \$0               |

## E. Extra “Optional Supplemental” benefits you can buy

*[Include this section if you offer optional supplemental benefits in the plan and describe benefits below. Plans must explain how these benefits are different than what is covered under Medicaid and must indicate if any of the optional supplemental benefits are covered by Medicaid. You may include this section either in the Member Handbook or as an insert to the Member Handbook.]*

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package. These extra benefits are called “**Optional Supplemental Benefits**.” If you want these optional supplemental benefits, you must sign up for them *[insert if applicable: and you may have to pay an additional premium for them.]* The optional supplemental benefits described in *[insert as applicable: this section OR the enclosed insert]* are subject to the same appeals process as any other benefits.

*[Insert plan specific optional supplemental benefits, premiums, deductible, copays, and coinsurance and rules using a chart like the Benefits Chart above. Insert plan specific procedures on how to elect optional supplemental coverage, including application process and effective dates and on how to discontinue optional supplemental coverage, including refund of premiums. Also, insert any restrictions on members’ re-applying for optional supplemental coverage (e.g., must wait until next annual enrollment period).]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## F. Our plan's visitor or traveler benefits

*[If your plan offers a visitor/traveler program to members who are out of your service area, insert this section, adapting and expanding the following paragraphs as needed to describe the traveler benefits and rules related to getting the out-of-area coverage. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR §422.74(b)(4)(iii) (for more than 6 months up to 12 months), also explain that here based on the language suggested below:]*

If you are out of the plan's service area for more than 6 months at a time but do not permanently move, we usually must disenroll you from our plan. However, we offer a visitor/traveler program *[specify areas where the visitor/traveler program is being offered]* that allows you to remain enrolled in our plan when you are outside of our service area for up to 12 months. Under our visitor/traveler program, you get all plan-covered services at in-network cost-sharing prices. Contact us for help in finding a provider when you use the visitor/traveler benefit.

If you are in a visitor/traveler area, you can stay enrolled in the plan until <end date>. If you don't return to our plan's service area by <end date>, we will end your membership in our plan.]

## G. Benefits covered outside of our plan

*[Plans should modify this section to include additional benefits covered outside the plan by Medicaid fee-for-service and/or a Medicaid managed care plan, as appropriate.]*

We don't cover the following services, but they are available through Medicare or *[insert name state-specific name of Medicaid program]*.

### G1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

#### For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

#### For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

#### For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook*.

**Note:** If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care not related to your terminal prognosis.

## H. Benefits not covered by our plan, Medicare, or *[insert name of state-specific Medicaid program]*.

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medicaid do not pay for them either.

Commented [BJ25]: Missing word: "pay"

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan does not cover the following items and services:

*[The services listed in the remaining bullets are excluded from Medicare's and Medicaid's benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Medicaid or have become covered due to a Medicare or Medicaid change in coverage policy, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans may add parenthetical references to the Benefits Chart for descriptions of covered services and items as appropriate. Plans may also add exclusions as needed.]*

- Services considered not "reasonable and medically necessary," according to Medicare and *[insert name state-specific name of Medicaid program]* standards, unless we list these as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Refer to **Chapter 3** of your *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it.
- A private room in a hospital, except when medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- *[Plans should delete this if the state allows:]* Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines.
- Routine foot care, except as described in Podiatry services in the Benefits Chart in Section D.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- *[Plans delete this if supplemental:]* Regular hearing exams, hearing aids, or exams to fit hearing aids.
- *[Plans delete this if supplemental:]* Radial keratotomy, LASIK surgery, and other low-vision aids.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. [\[Zero cost-sharing plans may adjust this language as applicable\]](#) However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

# Chapter 4: Benefits chart

## Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services *[insert if the plan has cost sharing: and how much you pay for each service]*. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

## Table of Contents

A. Your covered services *[insert if the plan has cost sharing: and your out-of-pocket costs]*.....2

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B. Rules against providers charging you for services.....2

C. About our plan’s Benefits Chart.....2

D. Our plan’s Benefits Chart.....6

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**If you have questions**, please call <plan name> at <toll-free phone and TTY/TDD numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 1

## A. Your covered services *[insert if the plan has cost sharing: and your out-of-pocket costs]*

This chapter tells you about services our plan covers *[insert if the plan has cost-sharing: and how much you pay for each service]*. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your *Member Handbook*. *[Insert if applicable: This chapter also explains limits on some services.]*

*[Plans with cost sharing, insert: For some services, are charged an out-of-pocket cost called a copay. This is a fixed amount (for example, \$5) you pay each time you get that service. You pay the copay at the time you get the medical service.]*

*[Plans with **no** cost-sharing for any services described in this chapter, insert: Because you get assistance from *[Insert name of state-specific Medicaid program]*, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of your *Member Handbook* for details about the plan's rules.]*

If you need help understanding what services are covered, call *[insert: your care coordinator and/or Member Services at <phone number(s)>]*.

*[As applicable, plans insert the subsection heading and information below.]*

### A1. During public health emergencies

*[Plans providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describe the coverage and flexibilities here or include general information about the coverage and flexibilities along with any cross references, as applicable. Plans include whether such coverage and flexibilities are contingent upon the duration of the public health emergency, which may or may not last for the entire year. Plans also include any specific contact information, as applicable, where members can get more details.]*

**Commented [ES1]:** Because some D-SNP members do have copays for Part D drugs (which are not described in this chapter) it might help to specify "covered **medical** services" here just to make it clear that we are not referring to absolutely everything. And maybe even add a sentence to this paragraph that tells them which chapter to go to for info about Part D drug costs.

## B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

**You should never get a bill from a provider for covered services.** If you do, refer to **Chapter 7** of your *Member Handbook* or call Member Services.

## C. About our plan's Benefits Chart



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans may add references to long-term care or home and community-based services.]*

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them. *[Plans that include an index at the end of the chapter should insert: To find a service in the chart, you can also use the index at the end of the chapter.]*

**We pay for the services listed in the Benefits Chart when the following rules are met.**

*[Plans that do not have cost-sharing, insert: You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.]*

- We provide covered Medicare and *[Insert name of state-specific Medicaid program]* covered services according to the rules set by Medicare and *[Insert name of state-specific Medicaid program]*.
- The services *[Plans may revise as applicable: (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs)]* must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise and use the state-specific definition of “medically necessary” and ensure that it is updated and used consistently in Chapter 12 and throughout member materials.]*
- *[Insert if applicable: You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care* or unless your plan or a network provider has given you a referral. **Chapter 3** of your *Member Handbook* has more information about using network and out-of-network providers.]
- *[Insert if applicable: You have a primary care provider (PCP) or a care team that is providing and managing your care. [Plans that do not require referrals, omit the rest of this paragraph:]* In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan’s network. This is called a referral. **Chapter 3** of your *Member Handbook* has more information about getting a referral and when you do **not** need one.]
- *[Insert if applicable: We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need prior authorization (PA) [insert as appropriate: with an asterisk (\*) or with a*

**Commented [ES2]:** The wording here is problematic because it isn't a *referral* that's needed to see an out-of-network provider, it's an *authorization*. The plan (not the provider) can give a member an authorization to see an out-of-network provider. Referrals are different and some plans are direct access plans and do not require referrals to see specialists, etc.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

footnote **or** in bold type *or* in italic type].] *[Insert if applicable: In addition, you must get prior authorization (PA) for the following services not listed in the Benefits Chart: [insert list].]*

- *[Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI)” in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Members with Certain Chronic Conditions**. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [insert if applicable: and/or reduced cost sharing]:*
  - *[List all applicable chronic conditions here.]*
  - *[If offering SSBCI, include information about the process and/or criteria for determining eligibility for SSBCI. Plan must also deliver a written summary of the SSBCI offered to each chronically ill member eligible for SSBCI.]*

Refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.]

- *[Insert as applicable: Most **or** All]* preventive services are free. You find this apple  next to preventive services in the Benefits Chart.
- *[Insert any additional applicable Medicaid program coverage here such as community supports]*

*[Instructions on completing the Benefits Chart:*

- *For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.*
- *Optional supplemental benefits are not permitted in this chart; optional supplemental benefits should be described in section E.*
- *Include the following where appropriate: Talk to your provider and get a referral.*
- *Plans must include any services provided in excess of the Medicare and Medicaid requirements and identify preventive services with the apple icon.*
- *HMO POS plan types must provide information about which services must be obtained from network providers, which services can be obtained out-of-network under the POS benefit, and any differences in cost sharing for covered services obtained out-of-network under the POS benefit.*

**Commented [ES3]:** Would it be possible to move the list of chronic conditions into the actual Benefits Chart? It seems odd to have that information here, and then in the chart, plans have to refer them *back* to this page to see what conditions are eligible.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Plans should clearly indicate which benefits are subject to prior authorization (PA). (This can be done with asterisks, footnotes, bold type, or italic type. Plans must select only one method of indication, describe it in terms easily understandable by members, make the indication and description prominently visible, and use it consistently throughout the document.)*
- *Plans may insert any additional benefit information that is based on the plan's approved benefit package and not already included in the Benefits Chart or in the exclusions section. Plans insert any additional benefits in the chart alphabetically.*
- *Plans must add any Medicaid benefits covered to the chart as instructed by the state. Insert any additional benefits in the chart alphabetically. If directed by the state, include all non-waiver services in the chart and all HCBS waiver services as a separate section after the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed. The remainder of the sections should then be renumbered.*
- *Plans must describe any restrictive policies, limitations, or monetary limits that might affect a member's access to services within the chart.*
- *Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.*
- *Plans should include all non-waiver LTSS in the chart in alphabetical order.*
- *Plans with no cost sharing for any type of service (i.e., no cost sharing at all) may delete the "what you must pay" column from the table. Plans with any type of cost sharing for services, including for pharmacy services, must leave the "what you must pay" column in the table.*
- *Plans offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:*
  - *Deliver to each clinically-targeted member a written summary of those benefits so that such member are notified of the "Uniformity Flexibility" benefits for which they are eligible.*
  - *Update the Benefits Chart to include details, as applicable, about the exact targeted reduced cost sharing amount for each specific service and/or the additional supplemental benefits being offered.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



D. Our plan’s Benefits Chart

[When a benefit continues from one page to the next, plans enter a blank return before right aligning and inserting at the bottom of the first part of the description: **This benefit is continued on the next page.** At the top of the next page where the benefit description continues, plans enter the benefit name again in bold followed by (continued). Plans may refer to **Durable medical equipment (DME) and related supplies** and other benefits later in this chart as examples. Plans should also be aware that the flow of benefits from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed.]

[Plans should modify this section throughout to reflect Medicaid or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medicaid.]

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                          | What you must pay                                        |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
|  | <p><b>Abdominal aortic aneurysm screening</b></p> <p>We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p> <p>[List any additional benefits offered.]</p> | <p>\$0</p> <p>[List copays for additional benefits.]</p> |

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
|  <b>Alcohol misuse screening and counseling</b><br><br>We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.<br><br>If you screen positive for alcohol misuse, you can get up to <b>four</b> brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.<br><br><i>[List any additional benefits offered.]</i> | <b>Acupuncture</b><br><br>We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: <ul style="list-style-type: none"><li>• lasting 12 weeks or longer;</li><li>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);</li><li>• not associated with surgery; <b>and</b></li><li>• not associated with pregnancy.</li></ul> In addition, we pay for an <b>additional 8 sessions</b> of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.<br><br>Acupuncture treatments must be stopped if you don't get better or if you get worse.<br><br><i>[List any additional benefits offered.]</i> | \$0<br><br><i>[List copays for additional benefits.]</i> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          |

Formatted: Highlight

**Commented [ES4]:** In other places, numerals have been used even for numbers below 10 (e.g., see highlighted use of 8 under Acupuncture above). Would it be possible to do that here (use 4) and throughout to be consistent? Numerals, from a health literacy standpoint, are easier to read and comprehend for many people.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | What you must pay                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|
|  <b>Ambulance services</b><br><br>Covered ambulance services include ground, air (airplane and helicopter), and rotary-wing ambulance services. The ambulance will take you to the nearest place that can give you care.<br><br>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases must be approved by us.<br><br>In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. |  | \$0                                                               |
|  <b>Annual wellness visit</b><br><br>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                                                                                                                                                                                                                                                  |  | \$0                                                               |
|  <b>Bone mass measurement</b><br><br>We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.<br><br>We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                          |  | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
|  <p><b>Breast cancer screening (mammograms)</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>One baseline mammogram between the ages of 35 and 39 <i>[plans that only cover ages 65 and older should delete]</i></li> <li>One screening mammogram every 12 months <i>[plans that cover women under 65 should include: for women age 40 and older]</i></li> <li>Clinical breast exams once every 24 months</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                    | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><b>Cardiac (heart) rehabilitation services</b></p> <p>We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's <i>[insert as appropriate: referral or order]</i>.</p> <p>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.</p>                                                                                                                                                                                                                                              | <p>\$0</p>                                                      |
|  <p><b>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</b></p> <p>We pay for one visit a year, or more if medically necessary, with your primary care provider to help lower your risk for heart disease. During the <i>[insert: visit or visits]</i>, your doctor may:</p> <ul style="list-style-type: none"> <li>Discuss aspirin use,</li> <li>Check your blood pressure, <b>and/or</b></li> <li>Give you tips to make sure you are eating well.</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
|  <b>Cardiovascular (heart) disease testing</b><br>We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                         | \$0<br><i>[List copays for additional benefits.]</i>                     |
|  <b>Cervical and vaginal cancer screening</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>For all women: Pap tests and pelvic exams once every 24 months</li> <li>For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months</li> <li><i>[Plans that cover women under 65 must include: For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months]</i></li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><i>[List copays for additional benefits.]</i>                     |
| <b>Chiropractic services</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>Adjustments of the spine to correct alignment</li> </ul> <i>[List any Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.]</i>                                                                                                                                                                                                                                                                                                                         | <i>[List copays.]</i><br><i>[List copays for supplemental benefits.]</i> |

Commented [ES5]: 5



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
|  <b>Colorectal cancer screening</b><br>For people <b>50</b> and older, we pay for the following services: <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema) every 48 months</li> <li>• Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months</li> <li>• DNA based colorectal screening, every 3 years</li> <li>• Screening Colonoscopy every <b>ten</b> years (but not within 48 months of a screening sigmoidoscopy)</li> <li>• Screening Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months.</li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><i>[List copays for additional benefits.]</i>                            |
| <i>[Include row if applicable and modify to accurately describe the Medicaid and/or supplemental benefit offered.]</i><br><b>Dental services</b><br>Certain dental services, including cleanings, fillings, and dentures, are available through the <i>[insert name of Medicaid program or integrated name]</i> Dental Program.<br><i>[Plans that offer optional supplemental dental benefits insert: Note: Our plan offers additional dental services. Got to Benefits Chart in Section E for more information.]</i>                                                                                                                                                                                                                                               | <i>[If plan offers supplemental benefit, the maximum copay amount is \$10.]</i> |
|  <b>Depression screening</b><br>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$0<br><i>[List copays for additional benefits.]</i>                            |

**Commented [ES6]:** The current recommendation is for people 45 and over. Can this be updated to be consistent with that?

**Commented [ES7]:** Could this be 10 instead of ten to be consistent?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                               |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
|  | <p><b>Diabetes screening</b></p> <p>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"><li>• High blood pressure (hypertension)</li><li>• History of abnormal cholesterol and triglyceride levels (dyslipidemia)</li><li>• Obesity</li><li>• History of high blood sugar (glucose)</li></ul> <p>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.</p> <p>Depending on the test results, you may qualify for up to <b>two</b> diabetes screenings every 12 months.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |

**Commented [ES8]:** Could this be 2 instead of two to be consistent?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | What you must pay                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <div data-bbox="154 464 191 499"></div> <p><b>Diabetic self-management training, services, and supplies</b></p> <p>We pay for the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> <li>Supplies to monitor your blood glucose, including the following: <ul style="list-style-type: none"> <li>A blood glucose monitor</li> <li>Blood glucose test strips</li> <li>Lancet devices and lancets</li> <li>Glucose-control solutions for checking the accuracy of test strips and monitors</li> </ul> </li> <li>For people with diabetes who have severe diabetic foot disease, we pay for the following: <ul style="list-style-type: none"> <li>One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, <b>or</b></li> <li>One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)</li> </ul> </li> <li>In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |

Commented [ES9]: Suggest 2

Commented [ES10]: Suggest 3



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Durable medical equipment (DME) and related supplies</b></p> <p>Refer to Chapter 12 of your <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).”</p> <p>We cover the following items:</p> <ul style="list-style-type: none"> <li>• Wheelchairs</li> <li>• Crutches</li> <li>• Powered mattress systems</li> <li>• Diabetic supplies</li> <li>• Hospital beds ordered by a provider for use in the home</li> <li>• Intravenous (IV) infusion pumps and pole</li> <li>• Speech generating devices</li> <li>• Oxygen equipment and supplies</li> <li>• Nebulizers</li> <li>• Walkers</li> <li>• Standard curved handle or quad cane and replacement supplies</li> <li>• Cervical traction (over the door)</li> <li>• Bone stimulator</li> <li>• Dialysis care equipment</li> </ul> <p>Other items may be covered.</p> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays, including how they vary for equipment covered by Medicare and Medicaid, if applicable.]</i></p> <p><i>[Include if applicable: Your cost sharing for Medicare oxygen equipment coverage is [insert copay amount or coinsurance percentage], every [insert required frequency of payment].]</i></p> <p><i>[Plans that use a constant cost-sharing structure for oxygen equipment insert: Your cost sharing will not change after being enrolled for 36 months.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay                                                                                                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Durable medical equipment (DME) and related supplies (continued)</b></p> <p><i>[Plans that do not limit the DME brands and manufacturers that they cover, insert: We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.]</i></p> <p><i>[Plans that limit the DME brands and manufacturers that they cover, insert the following (for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual): With this Member Handbook, we sent you our plan's list of DME. The list tells you the brands and makers of DME that we pay for. You may also find the most recent list of brands, makers, and suppliers on our website at &lt;URL&gt;.</i></p> <p>Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We do not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to our plan and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)</p> <p>If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor may file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is right for your medical condition. For more information about appeals, refer to <b>Chapter 9</b> of your <i>Member Handbook</i>.]</p> | <p><i>[Plans that wish to vary cost sharing for oxygen equipment after 36 months insert details including whether original cost sharing resumes after 5 years and you are still in the plan.] [If cost sharing is different for members who made 36 months of rental payments prior to joining the plan insert: If prior to enrolling in [insert plan name] is [insert cost sharing].]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Emergency care</b></p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> <li>Given by a provider trained to give emergency services, <b>and</b></li> <li>Needed to treat a medical emergency.</li> </ul> <p>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> <li>Serious risk to your health <i>[Plans that cover women under 65 must include: or to that of your unborn child]; or</i></li> <li>Serious harm to bodily functions; <b>or</b></li> <li>Serious dysfunction of any bodily organ or part; <b>or</b></li> <li><i>[Plans that cover women under 65 must include: In the case of a pregnant woman in active labor, when:</i> <ul style="list-style-type: none"> <li>There is not enough time to safely transfer you to another hospital before delivery.</li> <li>A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]</li> </ul> </li> </ul> <p><i>[Also identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.]</i></p> | <p><b>\$0</b></p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, <i>[plans should insert information as needed to accurately describe emergency care benefits: (e.g., you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.)]</i>.</p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| <p data-bbox="211 472 803 525"><i>[If family planning services are covered, plans should modify this as necessary.]</i></p> <p data-bbox="211 541 477 567"><b>Family planning services</b></p> <p data-bbox="211 590 776 672">The law lets you choose any provider for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p data-bbox="211 686 542 711">We pay for the following services:</p> <ul data-bbox="211 726 820 1297" style="list-style-type: none"> <li>• Family planning exam and medical treatment</li> <li>• Family planning lab and diagnostic tests</li> <li>• Family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring)</li> <li>• Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)</li> <li>• Counseling and diagnosis of infertility and related services</li> <li>• Counseling, testing, and treatment for sexually transmitted infections (STIs)</li> <li>• Counseling and testing for HIV and AIDS, and other HIV-related conditions</li> <li>• Permanent Contraception (You must be age 21 or older to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.)</li> <li>• Genetic counseling</li> </ul> <p data-bbox="211 1314 812 1396">We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:</p> <ul data-bbox="211 1411 820 1543" style="list-style-type: none"> <li>• Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)</li> <li>• Treatment for AIDS and other HIV-related conditions</li> <li>• Genetic testing</li> </ul> | <p data-bbox="883 472 1013 497"><i>[List copays.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                                      |
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|  <b>Health and wellness education programs</b><br><i>[These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness and stress management. Describe the nature of the programs here.]</i><br><i>[If this benefit is not applicable, plans should delete this row.]</i>                                                                                                                                                                                                             | <i>[List copays.]</i>                                                  |
| <i>[Plans should modify this section to reflect plan-covered benefits as appropriate.]</i><br><b>Hearing services</b><br>We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.                                                                                                                                                                                                                                                                                                                                                                | <i>[List copays.]</i><br><i>[List copays for additional benefits.]</i> |
| <i>[If this benefit is not applicable, plans should delete this row.]</i><br><b>Help with certain chronic conditions</b><br><i>[Plans that offer targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI),” which members with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits and (as applicable) reduced cost sharing. If offering SSBCI, plans must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package submission.]</i> | <i>[List copays.]</i>                                                  |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay                                    |
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|  <b>HIV screening</b><br>We pay for one HIV screening exam every 12 months for people who: <ul style="list-style-type: none"> <li>• Ask for an HIV screening test, <b>or</b></li> <li>• Are at increased risk for HIV infection.</li> </ul> For women who are pregnant, we pay for up to <b>three</b> HIV screening tests during a pregnancy.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                                                                                                                                                                             | \$0<br><i>[List copays for additional benefits.]</i> |
| <b>Home health agency care</b><br><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i><br>Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort.<br>We pay for the following services, and maybe other services not listed here: <ul style="list-style-type: none"> <li>• 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.)</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> </ul> | <i>[List copays.]</i>                                |

Commented [ES11]: Suggest 3



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                                                                   |
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| <p><b>Home infusion therapy</b></p> <p>Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:</p> <ul style="list-style-type: none"><li>• The drug or biological substance, such as an antiviral or immune globulin;</li><li>• Equipment, such as a pump; <b>and</b></li><li>• Supplies, such as tubing or a catheter.</li></ul> <p>Our plan covers home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"><li>• Professional services, including nursing services, provided in accordance with your care plan;</li><li>• Member training and education not already included in the DME benefit;</li><li>• Remote monitoring; <b>and</b></li><li>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.</li></ul> <p><a href="#">[List any additional benefits offered.]</a></p> | <p><a href="#">[List copays.]</a></p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                                                                                                    |
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| <p><b>Hospice care</b></p> <p>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have <u>six</u> months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Our plan pays for the following while you get hospice services:</p> <ul style="list-style-type: none"> <li>• Drugs to treat symptoms and pain</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul> <p><b>Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.</b></p> <ul style="list-style-type: none"> <li>• Refer to <b>Section F</b> of this chapter for more information.</li> </ul> <p><b>For services covered by our plan but not covered by Medicare Part A or Medicare Part B:</b></p> <ul style="list-style-type: none"> <li>• Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay <i>[insert as appropriate: our plan's cost-sharing amount or nothing]</i> for these services.</li> </ul> <p><b>For drugs that may be covered by our plan's Medicare Part D benefit:</b></p> <ul style="list-style-type: none"> <li>• Drugs are never covered by both hospice and our plan at the same time. For more information, refer to <b>Chapter 5</b> of your <i>Member Handbook</i>.</li> </ul> <p><b>Note:</b> If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that is <b>not</b> related to your terminal prognosis.</p> <p><i>[Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.]</i></p> | <p><i>[List copays.]</i></p> <p><i>[Include information about cost sharing for hospice consultation services if applicable.]</i></p> |

**Commented [ES12]:** Suggest 6

**Commented [BJ13]:** Hospice provider/Original Medicare pays for this:

Original Medicare will be billed for your hospice care, even if you're in a Medicare Advantage Plan. When you get hospice care, your Medicare Advantage Plan can still cover services that aren't a part of your terminal illness or any conditions related to your terminal illness.

Ch 4: An MA enrollee who elects hospice care, but chooses not to disenroll from the plan, is entitled to continue to receive through the plan any MA benefits other than those that are the responsibility of the hospice. Under such circumstances, the **MA** plan is paid a reduced capitation rate for that enrollee by CMS and the **MA plan** is responsible for continued coverage of supplemental benefits. CMS pays: (a) the hospice program for hospice care furnished to the enrollee and (b) the **MA plan**, providers, and suppliers for other Medicare-covered services furnished to the enrollee through the original Medicare program, subject to the usual rules of payment.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay                                                        |
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| <div data-bbox="154 464 191 499"></div> <p><b>Immunizations</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine</li> <li>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary</li> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B</li> <li>• COVID-19 vaccines</li> <li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li> </ul> <p>We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to <b>Chapter 6</b> of your <i>Member Handbook</i> to learn more.</p> <p><a href="#">[List any additional benefits offered.]</a></p> | <p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                    |
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| <p><b>Inpatient hospital care</b></p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p><i>[List any restrictions that apply.]</i></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units, such as intensive care or coronary care units</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Needed surgical and medical supplies</li> <li>• Appliances, such as wheelchairs</li> <li>• Operating and recovery room services</li> <li>• Physical, occupational, and speech therapy</li> <li>• Inpatient substance abuse services</li> <li>• In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><b>\$0</b></p> <p>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.</p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay |
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| <p><b>Inpatient hospital care (continued)</b></p> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. <i>[Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.]</i></p> <ul style="list-style-type: none"> <li>• Blood, including storage and administration</li> <li>• Physician services</li> </ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are you a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> |                   |
| <p><b>Inpatient services in a psychiatric hospital</b></p> <p>We pay for mental health care services that require a hospital stay. <i>[List days covered, restrictions such as 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.]</i></p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay |
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| <p><i>[Plans with no day limitations on a plan's hospital or nursing facility coverage may modify or delete this row as appropriate.]</i></p> <p><b>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</b></p> <p>We do not pay for your inpatient stay if it is not reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Doctor services</li> <li>• Diagnostic tests, like lab tests</li> <li>• X-ray, radium, and isotope therapy, including technician materials and services</li> <li>• Surgical dressings</li> <li>• Splints, casts, and other devices used for fractures and dislocations</li> <li>• Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: <ul style="list-style-type: none"> <li>○ An internal body organ (including contiguous tissue), <b>or</b></li> <li>○ The function of an inoperative or malfunctioning internal body organ.</li> </ul> </li> <li>• Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition</li> <li>• Physical therapy, speech therapy, and occupational therapy</li> </ul> | <p>\$0</p>        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
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| <p><b>Kidney disease services and supplies</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to <b>six</b> sessions of kidney disease education services.</li><li>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in <b>Chapter 3</b> of your <i>Member Handbook</i>, or when your provider for this service is temporarily unavailable or inaccessible.</li><li>• Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care</li><li>• Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments</li><li>• Home dialysis equipment and supplies</li><li>• Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply.</li></ul> <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.</p> | \$0               |

Commented [ES14]: Suggest 6



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | What you must pay                                               |
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|  <p><b>Lung cancer screening</b></p> <p>Our plan pays for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> <li>• Are aged 50-77, <b>and</b></li> <li>• Have a counseling and shared decision-making visit with your doctor or other qualified provider, <b>and</b></li> <li>• Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.</li> </ul> <p>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.</p> <p><i>[Modify section to accurately describe benefits and list any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                         | <p>\$0</p>                                                      |
|  <p><b>Medical nutrition therapy</b></p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when <i>[insert as appropriate: referred or ordered]</i> by your doctor.</p> <p>We pay for <b>three</b> hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.</p> <p>We pay for <b>two</b> hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's <i>[insert as appropriate: referral or order]</i>. A doctor must prescribe these services and renew the <i>[insert as appropriate: referral or order]</i> each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |

**Commented [ES15]:** Suggest 3

**Commented [ES16]:** Suggest 2



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
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|  <p><b>Medicare Diabetes Prevention Program (MDPP)</b></p> <p>Our plans pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none"> <li>• Long-term dietary change, <b>and</b></li> <li>• Increased physical activity, <b>and</b></li> <li>• Ways to maintain weight loss and a healthy lifestyle.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$0               |
| <p><b>Medicare Part B prescription drugs</b></p> <p><i>[Plans that do or expect to use Medicare Part B step therapy should indicate the Medicare Part B drug categories below that are or may be subject to Medicare Part B step therapy as well as a link to a list of drugs subject to Medicare Part B step therapy. Plans may update the link throughout the year and add any changes at least 30 days prior to implementation per 42 CFR 422.111(d).]</i></p> <p>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs:</p> <ul style="list-style-type: none"> <li>• Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <li>• Osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> </ul> <p><b>This benefit is continued on the next page</b></p> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay |
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| <p><b>Medicare Part B prescription drugs (continued)</b></p> <ul style="list-style-type: none"> <li>Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents <i>[plans may delete any of the following drugs that they do not not cover]</i> (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</li> <li>IV immune globulin for the home treatment of primary immune deficiency diseases</li> </ul> <p><i>[Insert if applicable: The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: &lt;hyperlink&gt;.]</i></p> <p>We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit.</p> <p><b>Chapter 5</b> of your <i>Member Handbook</i> explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p><b>Chapter 6</b> of your <i>Member Handbook</i> explains what you pay for your outpatient prescription drugs through our plan.</p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay            |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate or eliminate this section if not covered.]</i></p> <p><b>Nursing facility care</b></p> <p>A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital.</p> <p>Services that we pay for include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Nursing services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Respiratory therapy</li> <li>• Drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)</li> <li>• Blood, including storage and administration</li> <li>• Medical and surgical supplies usually given by nursing facilities</li> <li>• Lab tests usually given by nursing facilities</li> <li>• X-rays and other radiology services usually given by nursing facilities</li> <li>• Use of appliances, such as wheelchairs usually given by nursing facilities</li> <li>• Physician/practitioner services</li> <li>• Durable medical equipment</li> <li>• Dental services, including dentures</li> <li>• Vision benefits</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                               |
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| <p><b>Nursing facility care (continued)</b></p> <ul style="list-style-type: none"> <li>• Hearing exams</li> <li>• Chiropractic care</li> <li>• Podiatry services</li> </ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> <li>• A nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care).</li> <li>• A nursing facility where your spouse or domestic partner is living at the time you leave the hospital.</li> </ul> |                                                                 |
| <p> <b>Obesity screening and therapy to keep weight down</b></p> <p>If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                         | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
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| <p><b>Opioid treatment program (OTP) services</b></p> <p>Our plan pays for the following services to treat opioid use disorder (OUD):</p> <ul style="list-style-type: none"> <li>• Intake activities</li> <li>• Periodic assessments</li> <li>• Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications</li> <li>• Substance use counseling</li> <li>• Individual and group therapy</li> <li>• Testing for drugs or chemicals in your body (toxicology testing)</li> </ul> <p><i>[List any other medically necessary treatment or additional benefits offered, with the exception of meals and transportation.]</i></p> | \$0               |
| <p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy, including technician materials and supplies</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts, and other devices used for fractures and dislocations</li> <li>• Lab tests</li> <li>• Blood, including storage and administration</li> <li>• Other outpatient diagnostic tests</li> </ul> <p><i>[Plans can include other covered tests as appropriate.]</i></p>                   | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay                                               |
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| <p><b>Outpatient hospital services</b></p> <p>We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services <ul style="list-style-type: none"> <li>○ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.”</li> <li>○ Sometimes you can be in the hospital overnight and still be “outpatient.”</li> <li>○ You can get more information about being inpatient or outpatient in this fact sheet: <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a></li> </ul> </li> <li>• Labs and diagnostic tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies, such as splints and casts</li> <li>• Preventive screenings and services listed throughout the Benefits Chart</li> <li>• Some drugs that you can’t give yourself</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay                                               |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient mental health care</b></p> <p>We pay for mental health services provided by:</p> <ul style="list-style-type: none"> <li>• A state-licensed psychiatrist or doctor</li> <li>• A clinical psychologist</li> <li>• A clinical social worker</li> <li>• A clinical nurse specialist</li> <li>• A nurse practitioner</li> <li>• A physician assistant</li> <li>• Any other Medicare-qualified mental health care professional as allowed under applicable state laws</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient rehabilitation services</b></p> <p>We pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p>                                                                                                                                                                                                       | <p>\$0</p>                                                      |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay            |
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| <p><b>Outpatient substance abuse services</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Alcohol misuse screening and counseling</li> <li>• Treatment of drug abuse</li> <li>• Group or individual counseling by a qualified clinician</li> <li>• Subacute detoxification in a residential addiction program</li> <li>• Alcohol and/or drug services in an intensive outpatient treatment center</li> <li>• Extended-release Naltrexone (vivitrol) treatment</li> </ul> <p><i>[Modify this list accurately describe benefits offered or add any additional benefits offered.]</i></p>                                                                                        | <p><i>[List copays.]</i></p> |
| <p><b>Outpatient surgery</b></p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p>                   |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Partial hospitalization services</b></p> <p>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.</p> <p><i>[Network plans that do not have an in-network community mental health center may add: <b>Note:</b> Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.]</i></p> | <p>\$0</p>                   |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | What you must pay                                               |
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| <p><b>Physician/provider services, including doctor's office visits</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Medically necessary health care or surgery services given in places such as:</li><li>• Physician's office</li><li>• Certified ambulatory surgical center</li><li>• Hospital outpatient department</li><li>• Consultation, diagnosis, and treatment by a specialist</li><li>• Basic hearing and balance exams given by your <i>[insert as applicable: primary care provider or specialist]</i>, if your doctor orders them to find out whether you need treatment</li><li>• <i>[Insert if providing any additional telehealth benefits consistent with 42 CFR § 422.135 in the plan's approved Plan Benefit Package submission: Certain telehealth services, including [insert general description of covered additional telehealth benefits (i.e., the specific Medicare Part B service(s) the plan has identified as clinically appropriate for offering through electronic exchange when the provider is not in the same location as the member). Plans may refer members to their medical coverage policy here].]</i></li></ul> <p><b>This benefit is continued on the next page</b></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"><li>○ 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. <i>[Plans may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.]</i></li><li>○ <i>[List the available means of electronic exchange used for each Medicare Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.]</i></li><li>● <i>[Insert if the plan's service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act: Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare]</i></li><li>● Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home</li><li>● Telehealth services to diagnose, evaluate, or treat symptoms of a stroke</li><li>● Telehealth services for members with a substance use disorder or co-occurring mental health disorder</li></ul> <p><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> <li>○ You have an in-person visit within 6 months prior to your first telehealth visit</li> <li>○ You have an in-person visit every 12 months while receiving these telehealth services</li> <li>○ Exceptions can be made to the above for certain circumstances</li> </ul> </li> <li>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.</li> <li>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b> <ul style="list-style-type: none"> <li>○ you're not a new patient <b>and</b></li> <li>○ The check-in isn't related to an office visit in the past 7 days and</li> <li>○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> <li>• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours <b>if</b>: <ul style="list-style-type: none"> <li>○ you're not a new patient and</li> <li>○ The evaluation isn't related to an office visit in the past 7 days <b>and</b></li> <li>○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> </ul> <p><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay                                               |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient</li> <li>• Second opinion <i>[insert if appropriate: by another network provider]</i> before surgery</li> <li>• Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> <li>○ Surgery of the jaw or related structures</li> <li>○ Setting fractures of the jaw or facial bones</li> <li>○ Pulling teeth before radiation treatments of neoplastic cancer</li> <li>○ Services that would be covered when provided by a physician</li> </ul> </li> </ul> <p><i>[List any additional benefits offered.]</i></p> |                                                                 |
| <p><b>Podiatry services</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)</li> <li>• Routine foot care for members with conditions affecting the legs, such as diabetes</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p> <b>Prostate cancer screening exams</b></p> <p><i>[Plans that cover men under age 65 must include: For men age 50 and older,]</i> we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> <li>• A digital rectal exam</li> <li>• A prostate specific antigen (PSA) test</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                               |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Prosthetic devices and related supplies</b></p> <p>Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> <li>• Colostomy bags and supplies related to colostomy care</li> <li>• Pacemakers</li> <li>• Braces</li> <li>• Prosthetic shoes</li> <li>• Artificial arms and legs</li> <li>• Breast prostheses (including a surgical brassiere after a mastectomy)</li> </ul> <p>We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.</p> <p><i>[Plans that pay for prosthetic dental devices, delete the following sentence:]</i> We will not pay for prosthetic dental devices.</p> | <p>\$0</p>                                                      |
| <p><b>Pulmonary rehabilitation services</b></p> <p>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have <i>[insert as appropriate: a referral or an order]</i> for pulmonary rehabilitation from the doctor or provider treating the COPD.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay                                                        |
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| <div data-bbox="154 468 191 506"></div> <p><b>Sexually transmitted infections (STIs) screening and counseling</b></p> <p>We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered <a href="#">[plans that cover women under age 65 should include: for pregnant women and]</a> for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also pay for up to <b>two</b> face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.</p> <p><a href="#">[Also list any additional benefits offered.]</a></p> | <p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p> |

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | What you must pay |
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| <p><b>Skilled nursing facility (SNF) care</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"><li>• A semi-private room, or a private room if it is medically necessary</li><li>• Meals, including special diets</li><li>• Nursing services</li><li>• Physical therapy, occupational therapy, and speech therapy</li><li>• Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors</li><li>• Blood, including storage and administration</li><li>• Medical and surgical supplies given by nursing facilities</li><li>• Lab tests given by nursing facilities</li><li>• X-rays and other radiology services given by nursing facilities</li><li>• Appliances, such as wheelchairs, usually given by nursing facilities</li><li>• Physician/provider services</li></ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"><li>• A nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)</li><li>• A nursing facility where your spouse or domestic partner lives at the time you leave the hospital</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | What you must pay                                          |
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|  <b>Smoking and tobacco use cessation</b><br><br>If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit: <ul style="list-style-type: none"><li>We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.</li></ul><br>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: <ul style="list-style-type: none"><li>We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</li></ul><br><i>[List any additional benefits offered.]</i> |  | \$0<br><br><i>[List copays for supplemental benefits.]</i> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                            |
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| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay |
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| <p><b>Supervised exercise therapy (SET)</b></p> <p>We pay for SET for members with symptomatic peripheral artery disease (PAD) <i>[insert if applicable: who have a referral for PAD from the physician responsible for PAD treatment]</i>.</p> <p>Our plan pays for:</p> <ul style="list-style-type: none"><li>• Up to 36 sessions during a 12-week period if all SET requirements are met</li><li>• An additional 36 sessions over time if deemed medically necessary by a health care provider</li></ul> <p>The SET program must be:</p> <ul style="list-style-type: none"><li>• 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)</li><li>• In a hospital outpatient setting or in a physician's office</li><li>• Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD</li><li>• Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay |
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| <p><b>Urgently needed care</b></p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"><li>• A non-emergency that requires immediate medical care, <b>or</b></li><li>• A sudden medical illness, <b>or</b></li><li>• An injury, <b>or</b></li><li>• A condition that needs care right away.</li></ul> <p>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or during the weekend).</p> <p><i>[Include in-network benefits. Also identify whether this coverage is within the U.S. and its territories or is supplemental world-wide emergency/urgent coverage.]</i></p> | <p>\$0</p>        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | What you must pay                                                                 |
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|  <p><i>[Plans should modify this section to reflect Medicaid and plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]</i></p> <p><b>Vision care</b></p> <p>We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.</p> <p>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> <li>• People with a family history of glaucoma</li> <li>• People with diabetes</li> <li>• African-Americans <i>[plans that cover under 65 must include: who are age 50 and older]</i></li> <li>• Hispanic Americans <i>[plans that cover under 65 must include: who are 65 or older]</i></li> </ul> <p><i>[Plans should modify this description if the plan offers more than is covered by Medicare.]</i> We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.</p> <p>If you have <b>two</b> separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get <b>two</b> pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.</p> | <p><i>[List copays.]</i></p> <p><i>[List copays for additional benefits.]</i></p> |

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | What you must pay |
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|  <b>“Welcome to Medicare” preventive visit</b><br><br>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes: <ul style="list-style-type: none"><li>• A review of your health,</li><li>• Education and counseling about the preventive services you need (including screenings and shots), <b>and</b></li><li>• Referrals for other care if you need it.</li></ul> <b>Note:</b> We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. | \$0               |

## E. Extra “Optional Supplemental” benefits you can buy

*[Include this section if you offer optional supplemental benefits in the plan and describe benefits below. Plans must explain how these benefits are different than what is covered under Medicaid and must indicate if any of the optional supplemental benefits are covered by Medicaid. You may include this section either in the Member Handbook or as an insert to the Member Handbook.]*

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package. These extra benefits are called “**Optional Supplemental Benefits**.” If you want these optional supplemental benefits, you must sign up for them *[insert if applicable: and you may have to pay an additional premium for them.]* The optional supplemental benefits described in *[insert as applicable: this section OR the enclosed insert]* are subject to the same appeals process as any other benefits.

*[Insert plan specific optional supplemental benefits, premiums, deductible, copays, and coinsurance and rules using a chart like the Benefits Chart above. Insert plan specific procedures on how to elect optional supplemental coverage, including application process and effective dates and on how to discontinue optional supplemental coverage, including refund of premiums. Also, insert any restrictions on members’ re-applying for optional supplemental coverage (e.g., must wait until next annual enrollment period).]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## F. Our plan's visitor or traveler benefits

*[If your plan offers a visitor/traveler program to members who are out of your service area, insert this section, adapting and expanding the following paragraphs as needed to describe the traveler benefits and rules related to getting the out-of-area coverage. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR §422.74(b)(4)(iii) (for more than 6 months up to 12 months), also explain that here based on the language suggested below:]*

If you are out of the plan's service area for more than 6 months at a time but do not permanently move, we usually must disenroll you from our plan. However, we offer a visitor/traveler program *[specify areas where the visitor/traveler program is being offered]* that allows you to remain enrolled in our plan when you are outside of our service area for up to 12 months. Under our visitor/traveler program, you get all plan-covered services at in-network cost-sharing prices. Contact us for help in finding a provider when you use the visitor/traveler benefit.

If you are in a visitor/traveler area, you can stay enrolled in the plan until <end date>. If you don't return to our plan's service area by <end date>, we will end your membership in our plan.]

## G. Benefits covered outside of our plan

*[Plans should modify this section to include additional benefits covered outside the plan by Medicaid fee-for-service and/or a Medicaid managed care plan, as appropriate.]*

We don't cover the following services, but they are available through Medicare or *[insert name state-specific name of Medicaid program]*.

### G1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

#### For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

#### For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis

Commented [ES24]: Suggest 6



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

#### For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook*.

**Note:** If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care not related to your terminal prognosis.

## H. Benefits not covered by our plan, Medicare, or *[insert name of state-specific Medicaid program]*.

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medicaid do not pay for them either.

Commented [BJ25]: Missing word: "pay"

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan does not cover the following items and services:

*[The services listed in the remaining bullets are excluded from Medicare's and Medicaid's benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Medicaid or have become covered due to a Medicare or Medicaid change in coverage policy, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans may add parenthetical references to the Benefits Chart for descriptions of covered services and items as appropriate. Plans may also add exclusions as needed.]*

- Services considered not "reasonable and medically necessary," according to Medicare and *[insert name state-specific name of Medicaid program]* standards, unless we list these as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Refer to **Chapter 3** of your *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it.
- A private room in a hospital, except when medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- *[Plans should delete this if the state allows:]* Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines.
- Routine foot care, except as described in Podiatry services in the Benefits Chart in Section D.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- *[Plans delete this if supplemental:]* Regular hearing exams, hearing aids, or exams to fit hearing aids.
- *[Plans delete this if supplemental:]* Radial keratotomy, LASIK surgery, and other low-vision aids.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. [\[Zero cost-sharing plans may adjust this language as applicable\]](#) However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 5: Getting your outpatient prescription drugs

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### Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and *[Insert name of Medicaid program]*. *[Plans with no cost sharing, delete the next sentence.]* **Chapter 6** of your *Member Handbook* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

We also cover the following drugs, although they are not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please refer to Chapter 5, Section F "If you are in a Medicare-certified hospice program."

### Rules for our plan's outpatient drug coverage

*[If coverage includes Medicaid drugs, please add language as needed for Medicaid.]* We usually cover your drugs as long as you follow the rules in this section.

You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). *[Plans may modify or delete the next sentence as appropriate.]* It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists *[insert as applicable: or any similar Medicaid lists]*.

You generally must use a network pharmacy to fill your prescription.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "Drug List" for short.

- If it is not on the Drug List, we may be able to cover it by giving you an exception.
- Refer to Chapter 9 *[insert reference, as applicable]* to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration or supported by certain medical references. Your doctor may be able to help identify medical references to support the requested use of the prescribed drug. *[Plans should add definition of "medically accepted indication" as appropriate for Medicaid-covered drugs and items.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Getting your prescriptions filled

### A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website or contact Member Services *[insert if applicable: or your care coordinator]*.

### A2. Using your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy bills us for *[plans with cost-sharing, insert: our share of the cost of]* your covered prescription drug. *[Plans with no cost-sharing, delete the next sentence:]* You may need to pay the pharmacy a copay when you pick up your prescription.

If you don't have your plan ID card with you when you fill your prescription, ask the pharmacy to call us to get the necessary 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. Then you can ask us to pay you back *[insert if the plan has cost-sharing: for our share]*. **If you can't pay for the drug, contact Member Services right away.** We will do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of your *Member Handbook*.
- If you need help getting a prescription filled, contact Member Services *[insert if applicable: or your care coordinator]*.

### A3. What to do if you change your network pharmacy

*[Plans in which members do not need to take any action to change their pharmacies may delete the following sentence.]* If you change pharmacies and need a prescription refill, you can *[insert as applicable: either ask to have a new prescription written by a provider or]* ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services *[insert if applicable: or your care coordinator]*.

### A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services *[insert if applicable: or your care coordinator]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy. *[Plans may insert additional information about home infusion pharmacy services in the plan's network.]*
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services. *[Plans may insert additional information about LTC pharmacy services in the plan's network.]*
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies. *[Plans may insert additional information about I/T/U pharmacy services in the plan's network.]*
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services *[insert if applicable: or your care coordinator]*.

## A6. Using mail-order services to get your drugs

*[Plans that do not offer mail-order services, replace the information in this section with the following sentence: Our plan does **not** offer mail-order services.]*

*[Include the following information only if your mail-order service is limited to a subset of all formulary drugs, adapting terminology as needed: For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition.] [Insert if plan marks mail-order drugs in formulary: Drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List.] [Insert if plan marks non-mail-order drugs in formulary: Drugs **not** available through our plan's mail-order service are marked with *[plans should indicate how these drugs are marked]* in our Drug List.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Our plan's mail-order service *[insert as appropriate: allows or requires]* you to order *[insert as appropriate: at least a <number of days>-day supply of the drug and no more than a <number of days>-day supply or up to a <number of days>-day supply or a <number of days>-day supply]*. A <number of days>-day supply has the same copay as a one-month supply.

### Filling prescriptions by mail

To get *[insert if applicable: order forms and]* information about filling your prescriptions by mail, *[insert instructions]*.

Usually, a mail-order prescription arrives within <number of days> days. *[Insert plan's process for members to get a prescription if the mail-order is delayed.]*

### Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

#### 1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

*[Plans should include the appropriate information below from the following options, based on (1) whether the plan will automatically process new prescriptions consistent with the policy described in the December 12, 2013, CMS memorandum entitled "Clarification to the 2014 Policy on Automatic Delivery of Prescriptions," and 2016 Final Call Letter and (2) whether the plan offers an optional automatic refill program consistent with the policy described in the 2020 Final Call Letter. Plan sponsors who provide automatic delivery through retail or other non-mail means have the option to either add or replace the word "ship" with "deliver" as appropriate.]*

*[For new prescriptions received directly from health care providers, insert one of the following two options.]*

*[Plan sponsors that do not automatically process new prescriptions from provider offices, insert the following:]*

#### 2. New prescriptions the pharmacy gets from your provider's office

After the pharmacy gets a prescription from a health care provider, it contacts you to find out if you want the medication filled immediately or at a later time.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allows you to stop or delay the order before *[plans with cost sharing for drugs, insert: you are billed and]* it is shipped.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

*[Plan sponsors that **do** automatically process new prescriptions from provider offices, insert the following:]*

## 2. New prescriptions the pharmacy gets from your provider's office

The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by *[insert instructions]*.

*[Plans with no cost sharing for drugs, delete the following sentence:]* If you get a prescription automatically by mail that you do not want, and you were not contacted to find out if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, contact us by *[insert instructions]*.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before *[plans with cost sharing for drugs, insert: you are billed and]* it is shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by *[insert instructions]*.

*[For refill prescriptions, insert one of the following two options.]*

*[Plans that **do not** offer a program that automatically processes refills, insert the following:]*

## 3. Refills on mail-order prescriptions



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

For refills, contact your pharmacy *[insert recommended number of days]* days before your current prescription will run out to make sure your next order is shipped to you in time.

*[Plans that do offer a program that automatically processes refills, insert the following:]*

### 3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program *[optional: called <name of auto refill program>]*. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy *[insert recommended number of days]* days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program *[optional: insert name of auto refill program instead of “our program”]* that automatically prepares mail-order refills, contact us by *[insert instructions]*.

*[All plans offering mail-order services, insert the following:]*

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. *[Insert instructions on how members should provide their communication preferences.]*

### A7. Getting a long-term supply of drugs

*[Plans that do not offer extended-day supplies, replace the information in this section with the following sentence: Our plan does not offer long-term supplies of drugs.]*

You can get a long-term 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. *[Insert if applicable: When you get a long-term supply of drugs, your copay may be lower.]*

*[Delete if the plan does not offer extended-day supplies through network pharmacies.]* Some network pharmacies allow you to get a long-term supply of maintenance drugs. A <number of days>-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call *[insert if applicable: your care coordinator or]* Member Services for more information.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Delete if plan does not offer mail-order service.] [Insert as applicable: For certain kinds of drugs, you or You] can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** [insert reference, as applicable] to learn about mail-order services.*

### **A8. Using a pharmacy not in our plan's network**

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. *[Insert as applicable: We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.]*

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

*[Plans should insert a list of situations when they cover prescriptions out of the network (e.g., during a declared disaster) and any limits on their out-of-network policies (e.g., day supply limits, use of mail-order during extended out-of-area travel, authorization or plan notification).]*

In these cases, check with *[insert if applicable: your care coordinator or]* Member Services first to find out if there's a network pharmacy nearby.

### **A9. Paying you back for a prescription**

*[Plans may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]* If you must use an out-of-network pharmacy, you must generally pay the full cost *[plans with cost-sharing, insert: instead of a copay]* when you get your prescription. You can ask us to pay you back *[plans with cost-sharing, insert: for our share of the cost]*.

To learn more about this, refer to **Chapter 7** of your *Member Handbook*.

---

## **B. Our plan's Drug List**

We have a *List of Covered Drugs*. We call it the "Drug List" for short.

We select the drugs on the Drug List with the help of a team of doctors and pharmacists. The Drug List also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's Drug List when you follow the rules we explain in this chapter.

*[Plans that offer indication-based formulary design must include: If we cover a drug only for some medical conditions, we clearly identify it on our Drug List and in Medicare Plan Finder along with the specific medical conditions covered.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under *[Insert name of state Medicaid program]*.

*[Insert either of the two sentences: "Our Drug List includes brand name drugs and generic drugs." OR "Our Drug List includes brand name drugs, generic drugs, and biosimilars."]*

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

Generic drugs have the same active ingredients as brand name drugs. *[Insert if applicable: Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars.]* Generally, generic drugs *[Insert if applicable: and biosimilars]* work just as well as brand-name drugs *[Insert if applicable: or biological products]* and usually cost less. There are generic drug substitutes *[Insert if applicable: or biosimilar alternatives]* available for many brand name drugs *[Insert if applicable: and some biological products]*. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

## B2. How to find a drug on our Drug List

To find out if a drug you take is on our Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit our plan's website at <web address>. The Drug List on our website is always the most current one.
- Call *[insert if applicable: your care coordinator or]* Member Services to find out if a drug is on our Drug List or to ask for a copy of the list.

**Commented [AE1]:** The drug list is not always mailed. The requirement is to send an electronic notice that tells members where they can access the document online. Could "we sent you in the mail" either be bracketed or removed?

*[Plans may insert additional ways to find out if a drug is on the Drug List.]*

## B3. Drugs not on our Drug List

We don't cover all prescription drugs. Some drugs are not on our Drug List because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List.

*[Plans should remove or modify language regarding benefit exclusions when the benefits are covered by the plan under the Medicaid program.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



Our plan does not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and *[insert name of state-specific Medicaid program]* drugs) cannot pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the Food and Drug Administration (FDA) or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or *[Insert name of Medicaid program]* cannot cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Outpatient drugs made by a company that says you must have tests or services done only by them

#### **B4. Drug List** *[Plans that do not have cost sharing in any tier may omit: cost sharing] tiers*

Every drug on our Drug List is in one of <number of tiers> *[Plans that do not have cost sharing in any tier may omit: cost-sharing] tiers*. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter (OTC) drugs). *[Plans that do not have cost sharing in any tier may omit the following sentence: In general, the higher the cost-sharing tier, the higher your cost for the drug.]*

*[Plans must briefly describe each tier (e.g., Cost-sharing Tier 1 includes generic drugs, or for plans with no cost sharing in any tier, Tier 1 includes generic drugs). Plans must ensure the tier label or description of the types of drugs on each tier is consistent with guidance regarding*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*generic tier labels in the 2016 Final Call Letter. Indicate which is the lowest tier and which is the highest tier.]*

To find out which *[Plans that do not have cost sharing in any tier may omit: cost-sharing]* tier your drug is in, look for the drug on our Drug List.

**Chapter 6** of your *Member Handbook* tells the amount you pay for drugs in each *[Plans that do not have cost sharing in any tier may omit: cost sharing]* tier.

## C. Limits on some drugs

For certain prescription drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

**If there is a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug.** For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, ask us to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

*[Plans should include only the forms of utilization management the plan uses. Plans delete any they don't use and renumber the list accordingly.]*

### 1. Limiting use of a brand name drug when a generic version is available

Generally, a generic drug works the same as a brand name drug and usually costs less. *[Insert as applicable: In most cases, if or If]* there is a generic version of a brand name drug available, our network pharmacies give you the generic version.

- We usually do not pay for the brand name drug when there is an available generic version.
- However, if your provider *[insert as applicable: told us the medical reason that the generic drug won't work for you or wrote "No substitutions" on your prescription for a brand name drug or told us the medical reason that the generic drug or other covered drugs that treat the same condition will work for you]*, then we cover the brand name drug.
- *[Plans that offer all drugs at \$0 cost-sharing, delete the following sentence:]* Your copay may be greater for the brand name drug than for the generic drug.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## 2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from our plan before you fill your prescription. If you don't get approval, we may not cover the drug.

## 3. Trying a different drug first

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A does **not** work for you, then we cover Drug B. This is called step therapy.

## 4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services or check our website at <web address>. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to Chapter 9 of the *Member Handbook*.

---

## D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our Drug List. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above [\[insert reference, as applicable\]](#), some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

### D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our Drug List or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**To get a temporary supply of a drug, you must meet the two rules below:**

1. The drug you've been taking:
  - Is no longer on our Drug List **or**
  - Was never on our Drug List **or**
  - Is now limited in some way.
2. You must be in one of these situations:
  - *[Plans omit this scenario if the plan allows current members to ask for formulary exceptions in advance for the following year. Plans omit this scenario if the plan was not operating in the prior year.]* You were in our plan last year.
    - We cover a temporary supply of your drug **during the first [insert time period (must be at least 90 days)] days of the calendar year.**
    - This temporary supply is for up to *[insert supply limit (must be the number of days in plan's one-month supply)]* days.
    - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of *[insert supply limit (must be the number of days in plan's one-month supply)]* days of medication. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
  - You are new to our plan.
    - We cover a temporary supply of your drug **during the first [insert time period (must be at least 90 days)] days of your membership in our plan.**
    - This temporary supply is for up to *[insert supply limit (must be the number of days in plan's one-month supply)]* days.
    - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of *[insert supply limit (must be the number of days in plan's one-month supply)]* days of medication. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- You have been in our plan for more than *[insert time period (must be at least 90 days)]* days, live in a long-term care facility, and need a supply right away.
  - We cover one *[insert supply limit (must be at least a 31-day supply)]*-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - *[If applicable, plans insert their transition policy for current members with changes to their level of care.]*

## D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

**OR**

- Ask for an exception.

You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our Drug List or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

*[Plans that do not allow current members to ask for an exception prior to the beginning of the following contract year may omit this paragraph.]*

## D3. Asking for an exception

If a drug you take will be taken off our Drug List or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you need help asking for an exception, contact Member Services *[insert if applicable: or your care coordinator]*.

## E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our Drug List during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

**Commented [ES2]:** The term many plans use here is authorization rather than approval. Can that be an option here?

For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year** unless:

- A new, cheaper drug comes on the market that works as well as a drug on our Drug List now, **or**
- We learn that a drug is not safe, **or**
- A drug is removed from the market.

To get more information on what happens when our Drug List changes, you can always:

- Check our current Drug List online at <web address> **or**
- Call Member Services at the number at the bottom of the page to check our current Drug List.

Some changes to our Drug List happen **immediately**. For example:

- *[Plans that otherwise meet all requirements and want the option to immediately replace brand name drugs with their generic equivalents must provide the following advance general notice of changes: A new generic drug becomes available. Sometimes, a new generic drug comes on the market that works as well as a brand name drug on our Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug stays the same *[insert if applicable, for example, if the plan's Drug List has differential cost-sharing for some generics: or will be lower.]**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we send you information about the specific change we made once it happens.
- You or your provider can ask for an “exception” from these changes. We send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of your *Member Handbook* for more information on exceptions.]
- **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug’s manufacturer takes a drug off the market, we take it off our Drug List. If you are taking the drug, we tell you. *[Plans include information advising members what to do after they are notified (e.g., contact the prescribing doctor, etc.).]*

**We may make other changes that affect the drugs you take.** We tell you in advance about these other changes to our Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- *[Plans that want the option to immediately substitute a new generic drug, insert: We add a generic drug that is not new to the market and*
  - Replace a brand name drug currently on our Drug List **or**
  - Change the coverage rules or limits for the brand name drug.]
- *[Plans that are not making immediate generic substitutions insert: We add a generic drug and*
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.]

When these changes happen, we:

- Tell you at least 30 days before we make the change to our Drug List **or**
- Let you know and give you a *[insert supply limit (must be at least the number of days in the plan’s one-month supply)]*-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on our Drug List you can take instead **or**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you should ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

**We may make changes to drugs you take that do not affect you now.** For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally do not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking *[insert if applicable: , increase what you pay for the drug,]* or limit its use, then the change does not affect your use of the drug *[insert if applicable: or what you pay for the drug]* for the rest of the year.

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## F. Drug coverage in special cases

### F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you are admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your prescription drugs during your stay. You will not pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

*[Plans with no cost-sharing, delete this paragraph:]* To learn more about drug coverage and what you pay, refer to **Chapter 6** of your *Member Handbook*.

### F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has their own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not or if you need more information, contact Member Services.

### F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug that your hospice does not cover because it is not related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of your *Member Handbook* for more information about the hospice benefit.

---

## G. Programs on drug safety and managing drugs

### G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- May not be needed because you take another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we work with your provider to correct the problem.

### G2. Programs to help you manage your drugs

*[If plan has more than one medication therapy management program update language to reflect this.]* Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

Then, they will give you:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you do not want to be in the program, let us know, and we will take you out of it.

If you have questions about these programs, contact Member Services [\[insert if applicable: or your care coordinator\]](#).

### G3. Drug management program for safe use of opioid medications

Our plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid [\[insert if applicable: or benzodiazepine\]](#) medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications from [\[insert: a certain pharmacy or certain pharmacies\]](#) and/or from [\[insert: a certain doctor or certain doctors\]](#)
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter explains the limitations we think should apply.

**You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know.** If we decide to limit your coverage for



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization. To learn more about appeals and the Independent Review Organization, refer to **Chapter 9** of your *Member Handbook*.)

The DMP may not apply to you if you:

- Have certain medical conditions, such as cancer or sickle cell disease,
- Are getting hospice, palliative, or end-of-life care, **or**
- Live in a long-term care facility.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 6: What you pay for your Medicare and *[Insert name of Medicaid program]* Medicaid prescription drugs

### Introduction

This chapter tells what you pay for your outpatient prescription drugs. By “drugs,” we mean:

- Medicare Part D prescription drugs, **and**
- Drugs and items covered under Medicaid, **and**
- Drugs and items covered by our plan as additional benefits.

**Commented [BJ1]:** Perhaps this should be optional text?

Because you are eligible for *[insert state-specific name of Medicaid program]*, you get “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs. *[Plans who have \$0 cost sharing for all Medicare Part D drugs should remove the remaining language in this paragraph.]* We *[insert as appropriate: have included or sent you]* a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

**Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

To learn more about prescription drugs, you can look in these places:

- Our *List of Covered Drugs*.
  - We call this the “Drug List.” It tells you:
    - Which drugs we pay for
    - Which of the <number of tiers> *[Plans that do not have cost sharing in any tier may omit: cost-sharing]* tiers each drug is in
    - If there are any limits on the drugs



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at <web address>.
- **Chapter 5** of your *Member Handbook*.
  - It tells how to get your outpatient prescription drugs through our plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.
- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of your *Member Handbook* more information about network pharmacies.

*[Plans with no cost-sharing for all outpatient drugs, delete Sections D, E, F, and G and change section H to section D.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. The *Explanation of Benefits* (EOB)

*[Plans with a single payment stage (i.e., no cost-sharing differences between the Initial Coverage Stage and the Catastrophic Coverage Stage), modify this section as necessary.]*

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount we pay.

When you get prescription drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB is not a bill. The EOB has more information about the drugs you take *[insert, as applicable: such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options]*. The EOB includes:

- **Information for the month.** The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **Year-to-date information.** This is your total drug costs and total payments made since January 1.
- **Drug price information.** This is the total price of the drug and any percentage change in the drug price since the first fill.
- **Lower cost alternatives.** When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count towards your total out-of-pocket costs.
- *[Insert only if the plan pays for OTC drugs as part of its administrative costs under Medicare Part D, rather than as a Medicaid benefit: We also pay for some over-the-counter drugs. You do not have to pay anything for these drugs.]*
- To find out which drugs our plan covers, refer to our Drug List. *[Insert if applicable: In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under <insert state-specific name of Medicaid program>. These drugs are included in the Drug List.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

### 1. Use your plan ID card.

Show your plan ID card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

### 2. Make sure we have the information we need.

Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for *[insert if plan has cost-sharing: our share of the cost of]* the drug.

Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

For more information about asking us to pay you back for *[insert if plan has cost-sharing: our share of the cost of]* a drug, refer to **Chapter 7** of your *Member Handbook*.

### 3. Send us information about payments others have made 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, the Indian Health Service, and most charities count toward your out-of-pocket costs. *[Plans should delete the rest of this paragraph if they cover all Medicare Part D drugs at \$0 cost-sharing:]* This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

### 4. Check the EOBs we send you.

- When you get an EOB in the mail, make sure it is complete and correct.

○ Do you recognize the name of each pharmacy? Check the dates. Did you get drugs that day?

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If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.



- **Did you get the drugs listed?** Do they match those listed on your receipts?  
Do the drugs match what your doctor prescribed?

**Commented [E52]:** It seems that these two items should have been sub bullets of the previous item.

For more information, you can call <plan name> Member Services or read the <plan name> *Member Handbook*. *[Plans must include information about how to access the Member Handbook on the plan's website.]*

### What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this *Explanation of Benefits*, please call us at <plan name> Member Services. *[If applicable: You can also find answers to many questions on our website: <MMP web address>.]*

### What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at <plan name> Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- *[Plans may also insert additional State-based resources for reporting fraud.]*

If you think something is wrong or missing, or if you have any questions, call Member Services. *[Plans that allow members to manage this information online may describe that option here.]* Keep these EOBs. They are an important record of your drug expenses.

---

## C. *[Plans with two payment stages, insert: Drug Payment Stages for Medicare Part D drugs] [Plans with one payment stage, insert: You pay nothing for a one-month [insert if applicable: or long-term] supply of drugs]*

*[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following sentence: With our plan, you pay nothing for covered drugs as long as you follow our rules.]*

*[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), include the following paragraph and table.]*

There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Stage 1: Initial Coverage Stage                                                                                                                                                                             | Stage 2: Catastrophic Coverage Stage                                                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay.</p> <p>You begin in this stage when you fill your first prescription of the year.</p> | <p>During this stage, we pay all of the costs of your drugs through &lt;end date&gt;.</p> <p>You begin this stage when you have paid a certain amount of out-of-pocket costs.</p> |

*[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following information up to Section D.]*

**C1. Our** *[Plans that do not have cost sharing in any tier may omit: **cost-sharing**]*  
**tiers**

*[Plans must provide an explanation of tiers; refer to the examples below. Plans must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter.]*

*[Plans that have cost sharing in any tier include:* Cost-sharing tiers are groups of drugs with the same copay. Every drug on our Drug List is in one of <number of tiers> cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our Drug List.

*If a plan has no cost sharing for one or more tiers of drugs, the plan should modify the cost sharing information accordingly. Include examples such as the following:*

- Tier 1 drugs have the lowest copay. They may be generic drugs or non-Medicare drugs that are covered by Medicaid. The copay is from <amount> to <amount>, depending on your income.
- Tier 2 drugs have a medium copay. They are brand name drugs. The copay is from <amount> to <amount>, depending on your income.
- Tier 3 drugs have the highest copay. The copay is <amount>.]

*[Plans that do not have cost sharing in any tier include:* Tiers are groups of drugs on our plan's Drug List. Every drug on our Drug List is in one of <number of tiers> tiers. You have no copays for prescription and OTC drugs on our Drug List. To find the tiers for your drugs, refer to our Drug List.

*Include examples such as the following:*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Tier 1 drugs are generic drugs.
- Tier 2 drugs are brand name drugs.]

## C2. Your pharmacy choices

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

- a network pharmacy, **or**
- an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of your *Member Handbook* to find out when we do that. Refer to **Chapter 9** of the *Member Handbook* to learn about how to file an appeal if you are told a drug will not be covered.

To learn more about these pharmacy choices, refer to **Chapter 5** of your *Member Handbook* and our *Provider and Pharmacy Directory*.

## C3. Getting a long-term supply of a drug

*[Plans that do not offer extended supplies, delete the following two paragraphs:]*

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is *[insert if applicable: up to]* a <number of days>-day supply. *[Plans with cost-sharing, insert: It costs you the same as a one-month supply.]* *[Plans with no cost-sharing, insert: There is no cost to you for a long-term supply.]*

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Member Handbook* or our *Provider and Pharmacy Directory*.

## C4. What you pay

*[Plans that have copays on at least one tier must include the following language:]* You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Member Services to find out how much your copay is for any covered drug.

**Your share of the cost when you get a one-month *[insert if applicable: or long-term]* supply of a covered prescription drug from:**

*[Plans may delete columns and modify the table as necessary to reflect the plan’s prescription drug coverage. Include all possible copay amounts (not just the high/low ranges) – i.e., all three possible copay amounts for a tier in which LIS cost sharing applies – in the chart, as well as a statement that the copays for prescription drugs may vary based on the level of Extra Help the member gets (if the plan charges copays for any of its Medicare Part D drugs). Modify the chart as necessary to include \$0 copays for non-Medicare covered drugs. Plans must ensure the tier*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter.]*

*[Plans should add or remove tiers as necessary. Plans should remove references to “cost sharing” to describe tiers if they do not have cost sharing in any tier. If mail-order is not available for certain tiers, plans should insert the following text in the cost-sharing cell: Mail-order is not available for drugs in [insert tier].]*

|                                                                                           | <b>A network pharmacy</b>                          | <b>Our plan's mail-order service</b>               | <b>A network long-term care pharmacy</b> | <b>An out-of-network pharmacy</b>                                                                                                                |
|-------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                           | A one-month or up to a <number of days>-day supply | A one-month or up to a <number of days>-day supply | Up to a <number of days>-day supply      | Up to a <number of days>-day supply. Coverage is limited to certain cases. Refer to <b>Chapter 5</b> of your <i>Member Handbook</i> for details. |
| <b>Cost-sharing Tier 1</b><br><br>( <i>[Insert description; e.g., “generic drugs.”]</i> ) | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 2</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 3</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 4</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |

For information about which pharmacies can give you long-term supplies, refer to our plan's *Provider and Pharmacy Directory*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## D. Stage 1: The Initial Coverage Stage *[Plans with one coverage stage should delete this section]*

During the Initial Coverage Stage, we pay a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on the cost-sharing tier the drug is in and where you get it.

*[Plans must provide an explanation of tiers; refer to the examples below. Plans have flexibility to describe their tier model but must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter. Plans may also edit or delete language regarding Medicaid based on Medicaid coverage.]*

*[Plans that have cost sharing in any tier include:* Cost-sharing tiers are groups of drugs with the same copay. Every drug on our plan's Drug List is in one of <number of tiers> cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our Drug List.

- Tier 1 drugs have the lowest copay. They may be generic drugs or non-Medicare drugs that *[Insert state-specific name of Medicaid program]* covers. The copay is from <amount> to <amount>, depending on your income.
- Tier 2 drugs have a medium copay. They are brand name drugs. The copay is from <amount> to <amount>, depending on your income.
- Tier 3 drugs have the highest copay. The copay is <amount>.]

*[Plans that do not have cost sharing in any tier include:* Tiers are groups of drugs on our plan's Drug List. Every drug on our Drug List is in one of <number of tiers> tiers. You have no copay for prescription and OTC drugs on our Drug List. To find the tiers for your drugs, refer to our Drug List.

*Include examples such as the following:*

- Tier 1 drugs are generic drugs.
- Tier 2 drugs are brand name drugs.]

### D1. Your pharmacy choices

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

- A network pharmacy **or**
- An out-of-network pharmacy.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of your *Member Handbook* to find out when we do that.

To learn more about these choices, refer to **Chapter 5** of your *Member Handbook* and to our *Provider and Pharmacy Directory*.

## D2. Getting a long-term supply of a drug

*[Plans that do not offer extended supplies, delete the following two paragraphs:]*

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is *[insert if applicable: up to]* a <number of days>-day supply. *[Plans with cost-sharing, insert: It costs you the same as a one-month supply.] [Plans with no cost-sharing, insert: There is no cost to you for a long-term supply.]*

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Member Handbook* or our plan’s *Provider and Pharmacy Directory*.

## D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Member Services to find out how much your copay is for any covered drug.

**Your share of the cost when you get a one-month *[insert if applicable: or long-term]* supply of a covered prescription drug from:**

*[Plans may delete columns and modify the table as necessary to reflect the plan’s prescription drug coverage. Include all possible copay amounts (not just the high/low ranges) – i.e., all three possible copay amounts for a tier in which LIS cost sharing applies – in the chart, as well as a statement that the copays for prescription drugs may vary based on the level of Extra Help the member gets. Plans must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter.]*

*[Plans should add or remove tiers as necessary. Plans should remove references to “cost sharing” to describe tiers if they do not have cost sharing in any tier. If mail-order is not available for certain tiers, plans should insert the following text in the cost-sharing cell: Mail-order is not available for drugs in *[insert tier]*.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                           | <b>A network pharmacy</b>                          | <b>Our plan's mail-order service</b>               | <b>A network long-term care pharmacy</b> | <b>An out-of-network pharmacy</b>                                                                                                                |
|-------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                           | A one-month or up to a <number of days>-day supply | A one-month or up to a <number of days>-day supply | Up to a <number of days>-day supply      | Up to a <number of days>-day supply. Coverage is limited to certain cases. Refer to <b>Chapter 5</b> of your <i>Member Handbook</i> for details. |
| <b>Cost-sharing Tier 1</b><br><br>( <i>[Insert description; e.g., "generic drugs."]</i> ) | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 2</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 3</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 4</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |

For information about which pharmacies can give you long-term supplies, refer to our *Provider and Pharmacy Directory*.

#### D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Your Explanation of Benefits (EOB) helps you keep track of how much you have paid for your drugs during the year. We let you know if you reach the *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]* limit. Many people do not reach it in a year.

---

## E. Stage 2: The Catastrophic Coverage Stage *[Plans with one coverage stage should delete this section]*

When you reach the out-of-pocket limit of *[\$<TrOOP amount>]* for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, our plan pays all of the costs for your Medicare drugs.

---

## F. Your drug costs if your doctor prescribes less than a full month's supply *[Plans with no Medicare Part D drug cost-sharing should delete this section]*

*[Insert as appropriate: Usually or In some cases]*, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects).
- If your doctor agrees, you do not pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. 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.

- *[Plans may revise the information in this paragraph to reflect the appropriate number of days for their one-month supplies as well as the cost-sharing amount in the example.]* Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment is less than \$0.05 per day multiplied by 7 days, for a total payment less than \$0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:

**Commented [BJ3]:** Can this be updated for 2024 copay amount?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- Better plan when to refill your drugs,
- Coordinate refills with other drugs you take, **and**
- Take fewer trips to the pharmacy.

## G. Prescription cost-sharing assistance for persons with HIV/AIDS

*[Plans with no Medicare Part D drug cost-sharing delete this section]*

### G1. The AIDS Drug Assistance Program (ADAP)

The AIDS Drug Assistance Program (ADAP) helps eligible individuals living with HIV/AIDS access life-saving HIV medications. Outpatient Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the *[insert name of state-specific department]* for individuals enrolled in ADAP.

### G2. If you are not enrolled in ADAP

For information on eligibility criteria, covered drugs, or how to enroll in the program, call *[insert phone number]* or check the ADAP website at *[insert website address]*.

### G3. If you are enrolled in ADAP

ADAP can continue to provide ADAP clients with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. To be sure you continue getting this assistance, notify *[insert description of who to notify]* of any changes in your Medicare Part D plan name or policy number. If you need help finding the nearest ADAP enrollment site and/or enrollment worker, call *[insert phone number]* or check the website listed above.

## H. Vaccinations

*[Plans may revise this section as needed.]*

We cover Medicare Part D vaccines. There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

### H1. What you need to know before you get a vaccination

*[Plans may revise this section as needed.]*

**Commented [E54]:** Shouldn't this section be updated with the vaccine info from the September 6, 2022, HPMS memos "Updates to Part D Member Materials for Contract Year 2023" and "Additional Part D Updates to Contract Year 2023 Member Material Models for Medicare-Medicaid Plans and Minnesota Senior Health Options Plans?"



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We recommend that you call Member Services if you plan to get a vaccination.

- We can tell you about how our plan covers your vaccination *[insert if the plan has cost-sharing: and explain your share of the cost]*.
- *[Insert if applicable: We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider work with us to ensure that you have no upfront costs for a Medicare Part D vaccine.]*

Commented [ES5]: Missing word. Can? Will?

*[Plans that do not charge any Medicare Part D vaccine copays may delete the following section.]*

## H2. What you pay for a vaccination covered by Medicare Part D

Commented [ES6]: Aren't all Part D vaccines covered at no cost now?

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. *[Insert if applicable: You may have to pay a copay for Medicare Part D vaccines.]*

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
  - You pay *[insert as applicable: nothing or a copay]* for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
  - You pay *[insert as applicable: nothing or a copay]* to the doctor for the vaccine.
  - Our plan pays for the cost of giving you the shot.
  - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay *[insert as applicable: nothing or a copay]* for the vaccine.
3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
  - You pay *[insert as applicable: nothing or a copay]* for the vaccine.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Our plan pays for the cost of giving you the shot.

*[Insert any additional information about your coverage of vaccinations.]*



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

# Chapter 7: Asking us to pay *[plans with cost sharing, insert: our share of]* a bill you got for covered services or drugs

## Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans with an arrangement with the State may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits. Plans may not revise the chapter or section headings except as indicated.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

## Table of Contents

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| B. Sending us a request for payment .....            | 5 |
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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## A. Asking us to pay for your services or drugs

[Plans with cost sharing delete the next sentence.] You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We do not allow <plan name> providers to bill you for these services [insert as applicable: or drugs]. We pay our providers directly, and we protect you from any charges.

**If you get a bill for [plans with cost sharing insert: the full cost of] health care or drugs, do not pay the bill and send the bill to us.** To send us a bill, refer to [plans may insert reference, as applicable].

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid [plans with cost sharing, insert: more than your share of the cost; plans with no cost sharing, insert: the bill], it is your right to be paid back.
  - If you paid for services covered by Medicare, we will pay you back.
  - If you paid for services covered by [insert name of state-specific Medicaid program] we can't pay you back, but the provider will. Member services or [insert the term for your care coordinator] can help you contact the provider's office. Refer to the bottom of the page for the member services phone number.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services [insert if appropriate: or your care coordinator] if you have any questions. If [plans with cost sharing insert: you do not know what you should have paid, or if] you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

### 1. When you get emergency or urgently needed health care from an out-of-network provider

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back [plans with cost sharing insert: for our share of the cost]. Send us the bill and proof of any payment you made.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - If the provider should be paid, we will pay the provider directly.
  - If you already paid *[plans with cost sharing insert: more than your share of the cost]* for the Medicare service, we will *[plans with cost sharing insert: figure out how much you owed and]* pay you back *[plans with cost sharing insert: for our share of the cost]*.

## 2. When a network provider sends you a bill

Network providers must always bill us, it's important to show your plan ID card when you get any services or prescriptions. But sometimes they make mistakes, and ask you to pay for your services or more than your share of the costs. **Call Member Services** *[insert if appropriate: or your care coordinator]* at the number at the bottom of this page **if you get any bills.**

- *[Plans with no cost sharing, insert: Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.]*
- *[Plans with cost sharing, insert: As a plan member, you only pay the copay when you get services we cover. We don't allow providers to bill you more than this amount. This is true even if we pay the provider less than the provider charged for a service. Even if we decide not to pay for some charges, you still do not pay them.]*
- Whenever you get a bill from a network provider *[plans with cost sharing insert: that you think is more than you should pay]*, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, *[plans with cost sharing insert: but you feel that you paid too much,]* send us the bill and proof of any payment you made. We will pay you back *[insert as appropriate: for your covered services or for the difference between the amount you paid and the amount you owed under our plan]*.

## 3. If you are retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.

**Commented [ES1]:** Something seems to be missing here. This is a run-on sentence. Maybe just add "and" between the two clauses?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Send us the bill and proof of any payment you made.

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, will we cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back *[plans with cost sharing insert: for our share of the cost]*.
- Refer to **Chapter 5** of your *Member Handbook* to learn more about out-of-network pharmacies.

#### 5. When you pay the full *[insert if only applicable to Medicare Part D: Medicare Part D]* prescription cost because you don't have your plan ID card with you

If you don't have your plan ID card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your plan ID card.
- Send us a copy of your receipt when you ask us to pay you back *[plans with cost sharing insert: for our share of the cost]*.

#### 6. When you pay the full *[insert if only applicable to Medicare Part D: Medicare Part D]* prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Member Handbook*).
  - If you and your doctor or other prescriber think you need the drug right away, (within 72 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your *Member Handbook*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for *[plans with cost sharing insert: our share of the cost of]* the drug.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide the service or drug should be covered, we pay for *[insert if the plan has cost sharing: our share of the cost of]* it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your *Member Handbook*.

---

## B. Sending us a request for payment

*[Plans may edit this section to include a second address if they use different addresses for processing health care and drug claims.]*

*[Plans may edit this section as necessary to describe their claims process.]*

Send us your bill and proof of any payment you made for Medicare services *[Insert if allowed: or call us]*. Proof of payment can be a copy of the check you wrote or a receipt from the provider.

**It's a good idea to make a copy of your bill and receipts for your records.** *[Plans with care coordinators who can assist, insert: You can ask your care coordinator for help.] [Insert if applicable: You must send your information to us within [insert timeframe] of the date you received the service, item, or drug.]*

*[If the plan has a specific form for requesting payment, insert the following language: To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.]*

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website (<web address>), or you can call Member Services and ask for the form.]

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

*[Insert address.]*

*[If the plan allows members to submit oral payment requests, insert the following language:*

*You may also call us to ask payment.] [Plans include all applicable numbers and days and hours of operation.]*

*[Insert if applicable: You must submit your claim to us within <number of days> days of the date you got the service, item, or drug.]*

---

## C. Coverage decisions



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



**When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug.** We also decide the amount of money, if any, you must pay.

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay *[plans with cost sharing insert: our share of the cost]* for it. If you already paid for the service or drug, we will mail you a check for *[insert as applicable: what you paid or our share of the cost]*. If you haven't paid, we will pay the provider directly.

**Chapter 3** of your *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of your *Member Handbook* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for *[plans with cost sharing insert: our share of the cost of]* the service or drug, we will send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9 *[insert reference, as applicable]*.

---

## D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making an appeal." You can also make an appeal if you don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of your *Member Handbook*: *[plans may insert reference, as applicable]*.

- To make an appeal about getting paid back for a health care service, refer to **Section F** *[insert reference, as applicable]*.
- To make an appeal about getting paid back for a drug, refer to **Section G** *[insert reference, as applicable]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 8: Your rights and responsibilities

---

### Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Note: Plans may add to or revise this chapter as needed to reflect NCQA required language or language required by state Medicaid program.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Your right to get services and information in a way that meets your needs

*[Plans may edit the section heading and content to reflect the types of alternate format materials available to plan members. Plans may not edit references to language except as noted below.]*

*[Plans must insert a translation of this section in all languages that meet the language threshold.]*

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call *[insert if applicable: your care coordinator or]* Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials *[insert if required to provide materials in any non-English languages: in languages other than English and]* in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please **call or write to** *[Insert Plan name, address, and phone number]*. *[Plans specifically state which languages are offered. Plans also simply describe:*
  - *how they request a member's preferred language other than English and/or alternate format,*
  - *how they keep the member's information as a standing request for future mailings and communications so the member doesn't need to make a separate request each time, and*
  - *how a member can change a standing request for preferred language and/or format.]*

**Commented [ES1]:** Would it make more sense to refer them to the number at the bottom of the page as we do in other places? They would also be able to access an interpreter or use the TTY numbers if we did that.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- *[Plans should insert information about filing a complaint with Medicaid. Also, include any other state-required offices.]*
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## B. Our responsibility for your timely access to covered services and drugs

*[Plans may edit this section to add specific requirements for minimum access to care and remedies.]*

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Member Handbook*.
  - Call *[insert if applicable: your care coordinator or]* Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- *[Plans may edit this sentence to add other types of providers that members may use without a referral.]* Women have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that is not your PCP. *[If applicable, replace the previous sentences with: We do not require you to get referrals. or We do not require you to use network providers.]*
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Member Handbook*.
- *[Plans should include any additional state requirements regarding covered services or drugs here.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Chapter 9** of your *Member Handbook* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

---

## C. Our responsibility to protect your personal health information (PHI)

We protect your personal health information (PHI) as required by federal and state laws.

Your PHI includes information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights to when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

### C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws. *[Plans may insert similar information, as appropriate, about sharing medical records with Medicaid]*

### C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. *[Insert if applicable: We may charge you a fee for making a copy of your medical records.]*
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you have questions or concerns about the privacy of your PHI, call Member Services.

*[Plans may insert custom privacy practices.]*

---

## D. Our responsibility to give you information

*[Plans may edit the section to reflect the types of alternate format materials available to plan members and/or languages primarily spoken in the plan's service area.]*

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call us at <phone number>. This is a free service to you. *[Plans must insert information about the availability of written materials in languages other than English, stating specifically which languages are offered.]* We can also give you information in large print, braille, or audio. *[If applicable, plans insert information about the availability of written materials in other formats.]*

**Commented [ES2]:** Can we refer members to the number at the bottom of the page if that is the correct number?

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of your *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Member Handbook*) covered by our plan
  - limits to your coverage and drugs



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Member Handbook*), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

---

## E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of your *Member Handbook*.

---

## F. Your right to leave our plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another MA plan.
- Refer to **Chapter 10** of your *Member Handbook*:
  - For more information about when you can join a new MA or prescription drug benefit plan.
  - For information about how you will get your [\[Insert name of Medicaid program\]](#) benefits if you leave our plan.

---

## G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

### G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Member Handbook* tells how to ask us for a coverage decision.

## **G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself**

*[Note: Plans that would like to provide members with state-specific information about advance directives may do so. Include contact information for the appropriate state agency.]*

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you.**
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do **not** want.

The legal document that you use to give your directions is called an “advance directive.” There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You are not required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. *[Insert if applicable: You can also contact Member Services to ask for the form.]*
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- *[Insert any additional state-specific requirements as directed by the state.]*

Call Member Services for more information.

### G3. What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with *[plans insert the name and contact information of the applicable state-specific agency]*.

---

## H. Your right to make complaints and ask us to reconsider our decisions

**Chapter 9** of your *Member Handbook* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

### H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it is **not** about discrimination for reasons listed in **Chapter 11** of your *Member Handbook* – or you want more information about your rights, you can call:

- Member Services at *<insert phone and TTY numbers>*.
- The *[insert name of state-specific SHIP]* program at *[insert phone number]*. For more details about *[insert name of state-specific SHIP]*, refer to Chapter 2 *[insert reference, as applicable]*.
- *[Insert this section if applicable: The Ombudsman Program at <phone number>. For more details about this program, refer to Chapter 2 of your Member Handbook.]*

**Commented [ES3]:** Refer them to the number at the bottom of the page?

Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at [www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf](http://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf).)

*[If applicable, plans should insert additional contact information, such as for the state Medicaid agency.]*

## I. Your responsibilities as a plan member

*[Plans may modify this section to include additional member responsibilities. Plans may add information about estate recovery and other requirements mandated by the state.]*

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your *Member Handbook*. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your plan ID card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- *[Plans should edit the bullets below as needed to reflect the costs applicable to their members.]* **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most *<plan name>* members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.
  - *[Delete this bullet if the plan does not have cost sharing:]* For some of your *[insert if the plan has cost sharing for long-term services and supports: long-term services and supports [or drugs]]* covered by the plan, you must pay your share of the cost when you get the *[insert if the plan has cost sharing for services: service [or drug]]*. This will be a *[insert as appropriate: [copayment/copay] (a fixed amount) or coinsurance (a percentage of the total cost)]*. *[Insert if the plan has cost sharing for long-term services and supports: Chapter 4 [plans may insert reference, as applicable] tells what you must pay for your long-term services and supports.] Chapter 6 [plans may insert reference, as applicable] tells what you must pay for your drugs.*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (Note: If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to Chapter 9 [plans may insert reference, as applicable] to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call [insert if applicable: your care coordinator or] Member Services.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Member Handbook* tells about our service area.
  - We can help you find out if you're moving outside our service area. [Plans that do not offer plans outside the service area may delete the following sentence:] During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and [Insert state-specific name of Medicaid program] your new address when you move. Refer to **Chapter 2** of your *Member Handbook* for phone numbers for Medicare and [Insert name of state-specific Medicaid program].
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Call [insert if applicable: your care coordinator or] Member Services for help if you have questions or concerns.**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

*[Plans that integrate the description of Medicare and Medicaid processes must revise the sections of this chapter as needed to clearly describe the appeals and grievance processes.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[In cases where members should contact a department other than Member Services (for example, a grievance and appeals unit), plans should revise the instructions to provide the appropriate contact information.]*

## Introduction

This chapter has information about your rights. Read this chapter to find out what to do if: [\[Add any additional language for state-specific Medicaid information\]](#)

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                      |    |
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## A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints**; also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

### A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” instead of “Independent Review Entity”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

---

## B. Where to get help

### B1. For more information and help

Sometimes it's confusing to start or follow the process for dealing with a problem. This can be especially true if you don't feel well or have limited energy. Other times, you may not have the information you need to take the next step.

**Help from the** *[Insert state-specific name of the SHIP program]*

You can call the *[insert state-specific name of the SHIP program]*. *[insert state-specific name of the SHIP program]* counselors can answer your questions and help you understand what to do about your problem. *[Insert state-specific name of the SHIP program]* is not connected with us or with any insurance company or health plan. *[Insert state-specific name of the SHIP program]* has trained counselors in every county, and services are free. The *[insert state-specific name of the SHIP program]* phone number is *[insert phone number]*.



---

**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)).

### Help and information from *[insert name of state-specific Medicaid program]*

*[Insert contact information for the state Medicaid agency. Insert similar sections for the QIO or ombudsman, as applicable.]*

---

## C. Understanding Medicare and *[insert name of state-specific Medicaid program]* complaints and appeals in our plan

You have Medicare and *[insert name of state-specific Medicaid program]*. Information in this chapter applies to **all** of your Medicare and *[insert name of state-specific Medicaid program]* benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and *[insert state-specific name of Medicaid program]* processes.

Sometimes Medicare and *[insert state-specific name of Medicaid program]* processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a *[insert state-specific name of Medicaid program]* benefit. **Section F4** explains these situations.

---

## D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The chart below helps you find the right section of this chapter for problems or complaints.

**Commented [ES1]:** Could this say “the following chart” since it won’t necessarily be “below” depending on page breaks?



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                                                                               |                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| <b>Is your problem or concern about your benefits or coverage?</b><br><br>This includes problems about whether particular medical care or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs. |                                                                                                                           |
| <b>Yes.</b><br>My problem is about benefits or coverage.<br><br>Refer to <b>Section E</b> , "Coverage decisions and appeals."                                                                                                                                                 | <b>No.</b><br>My problem is not about benefits or coverage.<br><br>Refer to <b>Section K</b> , "How to make a complaint." |

## E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

### E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. We make a coverage decision whenever we decide what is covered for you and how much we pay. For example, your network doctor makes a favorable coverage decision for you whenever you get medical care from them or if they refer you to a medical specialist.

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or [\[insert state-specific name of Medicaid program\]](#). If you disagree with this coverage decision, you can make an appeal.

### E2. Appeals

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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 if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter *[insert reference, as applicable]*, you can ask for an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare medical service or item or Part B drugs, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

### E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- *[Insert name of SHIP program and contact information.]*
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

*[Insert any additional state-specific references for assistance with coverage decisions and appeals as applicable.]*

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the “Appointment of Representative” form. You can also get the form by visiting [www.cms.gov/Medicare/CMS-](http://www.cms.gov/Medicare/CMS-)



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

[Forms/CMS-Forms/downloads/cms1696.pdf](#) [plans may also insert: or on our website at <web address or link to form>]. You must give us a copy of the signed form.

#### E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, “Medical care” [insert reference, as applicable]
- **Section G**, “Medicare Part D prescription drugs” [insert reference, as applicable]
- **Section H**, “Asking us to cover a longer hospital stay” [insert reference, as applicable]
- **Section I**, “Asking us to continue covering certain medical services [insert reference, as applicable] (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page. [Plans may insert additional resources and contact information (e.g., SHIP, Ombudsman Program).]

**Commented [E52]:** Because these parentheses are inside another set of parentheses, they should be changed to square brackets to avoid confusion for reader. Alternatively, the parentheses around the whole sentence could be removed.

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### F. Medical care

[Plans may update the heading and terms such as “medical care” throughout to account for Medicaid services such as behavioral health and long-term care services as directed by the state.]

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for [insert if plan has cost sharing: our share of the cost of] your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of your *Member Handbook*. We generally refer to “medical care coverage” or “medical care” in the rest of this section. The term “medical care” includes medical services and items as well as Medicare Part B prescription drugs which are drugs administered by your doctor or health care professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

#### F1. Using this section

This section explains what you can do in any of the five following situations:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

1. You think we cover medical care you need but are not getting.

**What you can do:** You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

**What you can do:** You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we will not pay.

**What you can do:** You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

**What you can do:** You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

**What you can do:** You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

- If the coverage is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Refer to **Section H** *[insert reference, as applicable]* or **Section I** *[insert reference, as applicable]* to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

## F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **"integrated organization determination."**

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: *<phone number>* TTY: *<phone number>*.
- Faxing: *<phone number>*.
- Writing: *<address>*.

### Standard coverage decision



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

When we give you our decision, we use the “standard” deadlines unless we agree to use the “fast” deadlines. A standard coverage decision means we give you an answer about a:

- Medical service or item within 14 calendar days after we get your request. *[Plan may adjust timeframe if state has more restrictive requirement as directed by the state.]*
- Medicare Part B prescription drug within 72 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can’t take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a “fast complaint” about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, **Refer to Section K** *[insert reference, as applicable]*.

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#### Fast coverage decision

The legal term for “fast coverage decision” is “**expedited determination**.”

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a “fast coverage decision.” A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can’t take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a “fast complaint” about our decision to take extra days. For more information about making a complaint, including a fast complaint, **Refer to Section K** *[insert reference, as applicable]*. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- You are asking for coverage for medical care you **did not get**. You can't ask for a fast coverage decision about payment for medical care you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

**We automatically give you a fast coverage decision if your doctor tells us your health requires it.** If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K** *[insert reference, as applicable]*.

**Commented [ES4]:** I believe the bullet styles here should be swapped: this should be a first level bullet and the next two should be second level bullets.

**If we say No to part or all of your request**, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3** *[insert reference, as applicable]*).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- If the request is incomplete,
- If someone makes the request on your behalf but isn't legally authorized to do so, or
- If you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

### F3. Making a Level 1 Appeal



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



To start an appeal, you, your doctor, or your representative must contact us. Call us at <phone number> [insert additional contact information, as applicable].

Ask for a standard appeal or a fast appeal in writing or by calling us at <phone number>.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, [insert as applicable: you may need to name them as your representative to act on your behalf.]
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) [plans may also insert: or on our website at <web address or link to form>].
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

The legal term for "fast appeal" is "**expedited reconsideration.**"

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.

**Commented [ES5]:** Do we need to have the phone number listed in both of these places, one right after the other? If the number is the same, can we make note of that instead?

**Commented [ES6]:** I don't understand how this sentence works if you don't include the second optional part? It appears to be incomplete.

**Commented [ES7]:** Does this item need to be bulleted? If so, shouldn't it be a first level bullet?



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

- The process for a fast appeal is the same as for a fast coverage decision. To ask for a fast appeal, follow the instructions for asking for a fast coverage decision in **Section F2** *[insert reference, as applicable]*.
- If your doctor tells us that your health requires it, we will give you a fast appeal.

**If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.**

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.
  - If you do not appeal before these dates, then your service or medication will not be continued while you wait for your appeal decision.

**We consider your appeal and give you our answer.**

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

**There are deadlines for a fast appeal.**

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
- If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage if a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In <insert name of state> a Fair Hearing is called <insert description>.]*
- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request**, we send your appeal to the Independent Review Organization for a Level 2 Appeal.

**There are deadlines for a standard appeal.**

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If you think we should **not** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage if a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In <insert name of state> a Fair Hearing is called <insert description>.]*

If we say **Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights**:

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the Independent Review Organization for a Level 2 Appeal.
- If your problem is about coverage of a *[insert name of state-specific Medicaid program]* service or item, the letter tells you how to file a Level 2 Appeal yourself.

#### F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, *[insert name of state-specific Medicaid program]*, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that *[insert name of state-specific Medicaid program]* usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter *[insert reference, as applicable]*.
- If your problem is about a service or item that **both Medicare and** *[insert name of state-specific Medicaid program]* may cover, you automatically get a Level 2 Appeal with the Independent Review Organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** *[insert reference, as applicable]* for information about continuing your benefits during Level 1 Appeals.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the Independent Review Organization.
- If your problem is about a service that usually covered only by [\[insert state-specific name of Medicaid program\]](#), your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

**When your problem is about a service or item Medicare usually covers**

The Independent Review Organization reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**," sometimes called the "**IRE**."

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the Independent Review Organization, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The Independent Review Organization must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- 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 getting your appeal.
- If your request is for a Medicare Part B prescription drug, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

The Independent Review Organization gives you their answer in writing and explains the reasons.

- **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 Independent Review Organization's decision for **standard requests or**
  - Provide the service **within 72 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- **If the Independent Review Organization says Yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:**
  - **Within 72 hours** after we get the Independent Review Organization's decision for **standard requests or**
  - **Within 24 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- **If the Independent Review Organization says No to part or all of your appeal**, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- There are three additional levels in the appeals process after Level 2, for a total of five levels.
- If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
- An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** *[insert reference, as applicable]* for more information about Level 3, 4, and 5 Appeals.

**When your problem is about a service or item Medicaid usually covers, or that is covered by both Medicare and *[insert name of state-specific Medicaid program]***

A Level 2 Appeal for services that *[insert name of state-specific Medicaid program]* usually covers is a Fair Hearing with the state. In *<insert name of state>* a Fair Hearing is called *<insert description>*. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

*[Plans should describe the process for Medicaid Level 2 Appeals, in which members must submit the Level 2 Appeal themselves.]*

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the Independent Review Organization or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **Independent Review Organization**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the Independent Review Organization explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Refer to **Section J** *[insert reference, as applicable]* for more information about your appeal rights after Level 2.

## F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. *[Plans with cost sharing insert: The only amount you should be asked to pay is the copay for [insert service, item, and/or drug categories that require a copay].]*

*[Plans insert if the state DOES NOT allow members to be directly reimbursed for Medicaid benefits: We can't reimburse you directly for a Medicaid service or item. If you get a bill [plans with cost sharing insert: that is more than your copay] for Medicaid covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.]*

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to Chapter 7 of your Member Handbook.]

*[Plans insert if the state DOES allow members to be directly reimbursed for Medicaid benefits: If you get a bill [plans with cost sharing insert: that is more than your copay] for covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.]*

For more information, refer to Chapter 7 of your *Member Handbook*. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.]

- If the service or item you paid for is covered and you followed all the rules, we will send *[insert: you or your provider]* *[insert: the payment or if the plan has cost sharing, our share of the cost]* for the service or item within 60 calendar days after we get your request. *[Insert, as applicable: Your provider will then send the payment to you.]*

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If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3** *[insert reference, as applicable]*. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the Independent Review Organization. We will send you a letter if this happens.

- If the Independent Review Organization reverses our decision and says we should pay you, we must send the payment to you or to the provider 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 to you or to the health care provider within 60 calendar days.
- If the Independent Review Organization says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and *[insert name of Medicaid program]* usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information. *[Plans may edit as needed and/or provide additional instructions about the process for Level 2 payment appeals.]*

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## G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that *[insert name of state-specific Medicaid program]* may cover. **This section only applies to**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Medicare Part D drug appeals.** We'll say "drug" in the rest of this section. Instead of saying "Medicare Part D drug" every time. *[Insert as applicable and adjust language as directed by the state: For drugs covered only by Medicaid follow the process in Section E on page <insert page number>.]*

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Member Handbook* for more information about a medically accepted indication.

### G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - Cover a Medicare Part D drug that is not on our plan's Drug List or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

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

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

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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 make an appeal. Use the chart below to help you.

| Which of these situations are you in?                                                                             |                                                                                                                                                              |                                                                               |                                                                             |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.     | You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need. | You want to ask us to pay you back for a drug you already got and paid for.   | We told you that we won't cover or pay for a drug in the way that you want. |
| <b>You can ask us to make an exception.</b><br>(This is a type of coverage decision.)                             | <b>You can ask us for a coverage decision.</b>                                                                                                               | <b>You can ask us to pay you back.</b> (This is a type of coverage decision.) | <b>You can make an appeal.</b> (This means you ask us to reconsider.)       |
| Start with <b>Section G2</b> , then refer to <b>Sections G3 and G4</b> <i>[insert reference, as applicable]</i> . | Refer to <b>Section G4</b> <i>[insert reference, as applicable]</i> .                                                                                        | Refer to <b>Section G4</b> <i>[insert reference, as applicable]</i> .         | Refer to <b>Section G5</b> <i>[insert reference, as applicable]</i> .       |

**G2. Medicare Part D exceptions**

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

**1. Covering a drug that is not on our Drug List**

- *[Plans without cost sharing delete]* If we agree to make an exception and cover a drug that is not on our Drug List, you pay the copay that applies *[insert as appropriate: to all of our drugs or drugs in [insert exceptions tier] or drugs in [insert exceptions tier] for brand name drugs or [insert exceptions tier] for generic drugs]*.
- You can't get an exception to the required copay amount for the drug.

## 2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Member Handbook* for more information).
  - Extra rules and restrictions for certain drugs include:
    - *[Omit if the plan does not use generic substitution]* Being required to use the generic version of a drug instead of the brand name drug.
    - *[Omit if the plan does not use prior authorization (PA)]* Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
    - *[Omit if the plan does not use step therapy]* Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
    - *[Omit if the plan does not use quantity limits]* Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
  - *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit this bullet.]* If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.
3. *[Plans with no cost sharing and plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions, omit this section.]* **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of *[insert number of tiers]* cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

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

- Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
  - *[Plans that have a formulary structure where all biological products are on one tier or that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.
  - *[Plans that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
  - *[Plans that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.
- *[If the plan designated one of its tiers as a “specialty tier” and exempts that tier from the exceptions process, include the following language: You can’t ask us to change the cost-sharing tier for any drug in [insert tier number and name of tier designated as the high-cost/unique drug tier].]*
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can’t take, you usually pay the lowest amount.

### G3. Important things to know about asking for an exception

#### Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for 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 often includes more than one drug for treating a specific condition. These are called “alternative” drugs. If an alternative drug is just as effective as the drug you ask for and wouldn’t cause more side effects or other health problems, we generally do **not** approve your exception request. *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit the next sentence.]* If you ask us for a tiering exception, we generally do **not** approve your exception request unless all 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 you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar 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 exception request, you can make an appeal. Refer to **Section G5** *[insert reference, as applicable]* for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

#### **G4. Asking for a coverage decision, including an exception**

- Ask for the type of coverage decision you want by calling <phone number>, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** *[insert reference, as applicable]* to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.
- *[Plans that allow members to submit coverage determination requests electronically (e.g., through a secure member portal) may include a brief description of that process.]*

#### **If your health requires it, ask us for a "fast coverage decision."**

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

- You can get a fast coverage decision if:
  - It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
  - Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K** [\[insert reference, as applicable\]](#).

#### Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization. Refer to **Section G6** [\[insert reference, as applicable\]](#) for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

**Commented [ES8]:** It looks like the bullet levels for these items should be reversed—the first should be a first level bullet and the next two should be second level bullets.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

### Deadlines for a standard coverage decision about 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 send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

## G5. Making a Level 1 Appeal

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

- Start your **standard** or **fast appeal** by calling <phone number>, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your claim.
- You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



had a serious illness or we gave you the wrong information about the deadline.  
Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal.  
You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

A fast appeal is also called an “**expedited redetermination.**”

- If you appeal a decision we made about a drug you didn’t get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** *[insert reference, as applicable]* for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1**

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
- We give you our answer sooner if your health requires it.
  - If we don’t give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** *[insert reference, as applicable]* for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

**Deadlines for a standard appeal at Level 1**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** [\[insert reference, as applicable\]](#) for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** [\[insert reference, as applicable\]](#) for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

## G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **Independent Review Organization** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

The formal name for the “Independent Review Organization” is the “**Independent Review Entity**,” sometimes called the “**IRE**.”

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the Independent Review Organization **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you include **instructions about how to make a Level 2 Appeal** with the Independent Review Organization. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the Independent Review Organization, we send the information we have about your appeal to the organization. This information is called your “case file.” **You have the right to a free copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

The Independent Review Organization reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** *[insert reference, as applicable]* for more information about the Independent Review Organization.

#### **Deadlines for a fast appeal at Level 2**

If your health requires it, ask the Independent Review Organization for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the Independent Review Organization's decision.

#### **Deadlines for a standard appeal at Level 2**

If you have a standard appeal at Level 2, the Independent Review Organization must give you an answer:

- **Within 7 calendar days** after they get your appeal for a drug you didn't get.
- **Within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the Independent Review Organization says **Yes** to part or all of your request:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We must provide the approved drug coverage **within 72 hours** after we get the Independent Review Organization's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the Independent Review Organization's decision.
  - If the Independent Review Organization says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

**Commented [ES9]:** Shouldn't this be a first level bullet? It doesn't follow from the one above it.

If the Independent Review Organization says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The Independent Review Organization sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the Independent Review Organization says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the Independent Review Organization sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

## H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Member Handbook*.

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

## H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Call Medicare at 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit [www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices).

## H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In *[insert name of state]*, the Quality Improvement Organization is *[insert state-specific QIO name]*. Call them at *[insert QIO toll-free phone number]*. Contact information is also in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**.

**Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date.**

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the Quality Improvement Organization’s decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, appeal to our plan directly instead. Refer to **Section G4** *[insert reference, as applicable]* for information about making an appeal to us.

**Ask for help if you need it.** If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the *[insert name of state SHIP including contact information]*.

**Ask for a fast review.** Act quickly and contact the Quality Improvement Organization to ask for a fast review of your hospital discharge.

The legal term for “**fast review**” is “**immediate review**” or “**expedited review**.”



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### What happens during fast review

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the “**Detailed Notice of Discharge.**” You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices).

Within one full day after getting all of the information it needs, the Quality Improvement Organization give you their answer to your appeal.

If the Quality Improvement Organizations says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Improvement Organization says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- 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 their answer to your appeal.
- You can make a Level 2 Appeal if the Quality Improvement Organization turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

### H3. Making a Level 2 Appeal



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at [\[insert QIO toll-free phone number\]](#).

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

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Quality Review Organization says **Yes** to your appeal:

- We must pay you back for [\[plans with cost sharing should include: our share of\]](#) hospital care costs since noon on the day after the date the Quality Improvement Organization turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Review Organization says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

#### H4. Making a Level 1 Alternate Appeal

The deadline for contacting the Quality Improvement Organization for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

The legal term for "fast review" or "fast appeal" is "**expedited appeal**."

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any [\[plans with cost sharing should include: share\]](#) of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of giving saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** [\[insert reference, as applicable\]](#) for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- Home health care services
- Skilled nursing care in a skilled nursing facility
- Rehabilitation care as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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.

### I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

### I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** *[insert reference, as applicable]* for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the *[insert state name of SHIP program and contact information]*.
- **Contact the Quality Improvement Organization.**
  - Refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal."** Ask the Quality Improvement Organization if it's medically appropriate for us to end coverage of your medical services.

#### Your deadline for contacting this organization

- 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 we sent you.
- If you miss the deadline for contacting the Quality Improvement Organization, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4** *[insert reference, as applicable]*.

The legal term for the written notice is "**Notice of Medicare Non-Coverage.**" To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or get a copy online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices).

#### What happens during a fast-track appeal



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is “**Detailed Explanation of Non-Coverage.**”

- Reviewers tell you their decision within one full day after getting all the information they need.

If the Independent Review Organization says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying *[plans with cost sharing should include: our share of]* the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

### **I3. Making a Level 2 Appeal**

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at *[insert QIO toll-free phone number]*.

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 continue care after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** *[insert reference, as applicable]* for information about Level 3, 4, and 5 Appeals.

#### **I4. Making a Level 1 Alternate Appeal**

As explained in **Section I2** *[insert reference, as applicable]*, you must act quickly and contact the Quality Improvement Organization to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review.”

The legal term for “fast review” or “fast appeal” is “**expedited appeal**.”

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We agree to pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- If we say **No** to your fast appeal:
- Our coverage for these services ends on the date we told you.
- We will not pay any *[plans with cost sharing should include: share]* of the costs after this date.
- You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### 15. Making a Level 2 Alternate Appeal

During the Level 2 Appeal,

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** *[insert reference, as applicable]* for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## J. Taking your appeal beyond Level 2

### J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the Independent Review Organization for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we 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 service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 reviews your appeal and gives you an answer. The Council is part of the federal government.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

#### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

**Commented [ES10]:** This should be a first level bullet, not a second level.

#### J2. Additional *[insert name of state-specific Medicaid program]* appeals

You also have other appeal rights if your appeal is about services or items that *[insert name of state-specific Medicaid program]* usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

*[Plans may, at the discretion of the state, insert a clear, brief description of the procedures, timing, and instructions about what members need to do if they want to file an additional appeal in the state.]*

#### J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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.

**Commented [ES11]:** I don't think this item should be bulleted at all. Should mirror the "If Yes" statement above.

#### Level 4 Appeal

The Medicare Appeals Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

#### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

**Commented [ES12]:** This should be a first level bullet.

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## K. How to make a complaint

### K1. What kinds of problems should be complaints



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

| Complaint                                                             | Example                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Quality of your medical care</b>                                   | <ul style="list-style-type: none"> <li>You are unhappy with the quality of care, such as the care you got in the hospital.</li> </ul>                                                                                                                                                                                                                                                                        |
| <b>Respecting your privacy</b>                                        | <ul style="list-style-type: none"> <li>You think that someone did not respect your right to privacy or shared confidential information about you.</li> </ul>                                                                                                                                                                                                                                                 |
| <b>Disrespect, poor customer service, or other negative behaviors</b> | <ul style="list-style-type: none"> <li>A health care provider or staff was rude or disrespectful to you.</li> <li>Our staff treated you poorly.</li> <li>You think you are being pushed out of our plan.</li> </ul>                                                                                                                                                                                          |
| <b>Accessibility and language assistance</b>                          | <ul style="list-style-type: none"> <li>You cannot physically access the health care services and facilities in a doctor or provider's office.</li> <li>Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish).</li> <li>Your provider does not give you other reasonable accommodations you need and ask for.</li> </ul> |
| <b>Waiting times</b>                                                  | <ul style="list-style-type: none"> <li>You have trouble getting an appointment or wait too long to get it.</li> <li>Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.</li> </ul>                                                                                                                                                          |
| <b>Cleanliness</b>                                                    | <ul style="list-style-type: none"> <li>You think the clinic, hospital or doctor's office is not clean.</li> </ul>                                                                                                                                                                                                                                                                                            |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Complaint                                           | Example                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Information you get from us                         | <ul style="list-style-type: none"> <li>You think we failed to give you a notice or letter that you should have received.</li> <li>You think written information we sent you is too difficult to understand.</li> </ul>                                                                                                                                                                                                                               |
| Timeliness related to coverage decisions or appeals | <ul style="list-style-type: none"> <li>You think we don't meet our deadlines for making a coverage decision or answering your appeal.</li> <li>You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services.</li> <li>You don't think we sent your case to the Independent Review Organization on time.</li> </ul> |

**There are different kinds of complaints.** You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call [\[insert contacts and contact information\]](#).

The legal term for a “complaint” is a “**grievance.**”

The legal term for “making a complaint” is “**filing a grievance.**”

## K2. Internal complaints

To make an internal complaint, call Member Services at [<phone number>](#). You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *[Insert additional description of the procedures (including time frames) and instructions about what members need to do if they want to use the process for making a complaint, including a fast complaint.]*

**The legal term for “fast complaint” is “expedited grievance.”**

If possible, we 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. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don’t make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don’t agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

### K3. External complaints

#### Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). You do not need to file a complaint with *[insert plan name]* before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

*[Insert additional Medicaid information as required by the state.]*

#### Office for Civil Rights



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

You can make a complaint to the Department of Health and Human Services Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for more information.

You may also contact the local Office for Civil Rights office at:

*[Plans should insert contact information for the OCR regional office.]*

You may also have rights under the Americans with Disability Act and under *[plans may insert relevant state law]*. You can contact *[insert contacts and contact information]*.

### Quality Improvement Organization

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the Quality Improvement Organization.
- You can make your complaint to the Quality Improvement Organization and to our plan. If you make a complaint to the Quality Improvement Organization, we work with them to resolve your complaint.

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. To learn more about the Quality Improvement Organization, refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook*.

In *<state>*, the Quality Improvement Organization is called *<state-specific QIO name>*. The phone number for *<state-specific QIO name>* is *<phone number>*.



**If you have questions**, please call *<plan name>* at *<toll-free phone and TTY numbers>*, *<days and hours of operation>*. The call is free. **For more information**, visit *<web address>*.

## Chapter 12: Definitions of important words

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### Introduction

This chapter includes key terms used throughout your *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans should insert additional definitions not included in this model and exclude model definitions not applicable to your plan, your contractual obligations with CMS or enrolled beneficiaries. Plans should modify definitions as appropriate in the state and/or as directed by the state.]*

*[When plans use key terms in the Member Handbook, they explain the term in the first section where it appears along with a reference to Chapter 12.]*

*[If plans revise terminology (e.g., "Member Services" to "Customer Service," "Care Coordinator" to "Care Manager") that affect glossary terms, plans use the revised term consistently throughout the Member Handbook and alphabetize it in this chapter.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Activities of daily living (ADL):** The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

**Aid paid pending:** You can continue getting your benefits while you are waiting for a decision about a Level 1 Appeal or a State Hearing (Refer to **Chapter 9** of your *Member Handbook* for more information). This continued coverage is called “aid paid pending.”

**Commented [ES1]:** This is an unfamiliar term. Is it optional?

**Ambulatory surgical center:** A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

**Appeal:** A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your *Member Handbook* explains appeals, including how to make an appeal.

**Behavioral Health:** An all-inclusive term referring to mental health and substance use disorders.

**Brand name drug:** A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

**Care coordinator:** One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

**Care plan:** Refer to “Individualized Care Plan.”

**Care team:** Refer to “Interdisciplinary Care Team.”

*[Plans with a single coverage stage should delete this paragraph.]* **Catastrophic coverage stage:** The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you reach the \$<TrOOP amount> limit for your prescription drugs.

**Centers for Medicare & Medicaid Services (CMS):** The federal agency in charge of Medicare. **Chapter 2** of your *Member Handbook* explains how to contact CMS.

**Complaint:** A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

**Comprehensive outpatient rehabilitation facility (CORF):** A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans that do not have copays should delete this paragraph.]* **Copay:** A fixed amount you pay as your share of the cost each time you get certain *[insert if applicable: services or]* prescription drugs. For example, you might pay \$2 or \$5 for *[insert if applicable: a service or]* a prescription drug.

*[Plans that do not have cost sharing should delete this paragraph.]* **Cost sharing:** Amounts you have to pay when you get certain *[insert if applicable: services or]* prescription drugs. Cost sharing includes copays.

*[Plans that do not have cost sharing should delete this paragraph.]* **Cost sharing tier:** A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List) is in one of *[insert number of tiers]* cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

**Coverage decision:** A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your *Member Handbook* explains how to ask us for a coverage decision.

**Covered drugs:** The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

**Covered services:** The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

**Cultural competence training:** Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

*[Plans that do not have cost sharing for Medicare Part D drugs should delete this paragraph. Plans may revise the information in this definition to reflect the appropriate number of days for their one-month supplies as well as the cost-sharing amount in the example.]* **Daily cost sharing rate:** A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost sharing rate is the copay divided by the number of days in a month's supply.

Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment is less than \$0.05 per day multiplied by 7 days, for a total payment less than \$0.35.

**Disenrollment:** The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

**Commented [BJ2]:** Will this be updated for the current 2024 copay amount?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



*[Plans that do not have cost sharing add this paragraph.]* **Drug tiers:** Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of *[insert number of tiers]* tiers.

**Dual eligible special needs plan (D-SNP):** Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

**Durable medical equipment (DME):** Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

**Emergency:** A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function *[insert as applicable: (and if you are a pregnant woman, loss of an unborn child)]*. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

**Emergency care:** Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

**Exception:** Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

**Excluded Services:** Services that are not covered by this health plan.

**Extra Help:** Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

**Generic drug:** A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

**Grievance:** A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

**Health plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

**Health risk assessment:** A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**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 (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

**Hospice:** A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

**Improper/inappropriate billing:** A situation when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. Call Member Services if you get any bills you don't understand.

*[Plans with cost sharing, insert: As a plan member, you only pay our plan's cost sharing amounts when you get services we cover. We do **not** allow providers to bill you more than this amount.]*

*[Plans with no cost sharing, insert: Because we pay the entire cost for your services, you do **not** owe any cost sharing. Providers should not bill you anything for these services.]*

**Individualized Care Plan (ICP or Care Plan):** A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

*[Plans with a single coverage stage delete this paragraph.]* **Initial coverage stage:** The stage before your total Medicare Part D drug expenses reach \$*[insert initial coverage limit]*. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

**Inpatient:** A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

**Interdisciplinary Care Team (ICT or Care team):** A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**List of Covered Drugs (Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary.”

**Long-term services and supports (LTSS):** Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don’t have to go to a nursing facility or hospital. LTSS include Community Based Services and Nursing Facilities (NF).

**Low-income subsidy (LIS):** Refer to “Extra Help.”

*[Insert name of Medicaid program]*: This is the name of *[insert name of state]* Medicaid program. *[Insert name of Medicaid program]* is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medicaid (or Medical Assistance):** A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

**Medically necessary:** This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise and use the state-specific definition of “medically necessary” and update and use it consistently throughout member materials.]*

**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). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

**Medicare Advantage:** A Medicare program, also known as “Medicare Part C” or “MA,” that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

**Medicare-covered services:** Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part B.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Medicare-Medicaid enrollee:** A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual.”

**Medicare Part A:** The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

**Medicare Part B:** The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

**Medicare Part C:** The Medicare program, also known as “Medicare Advantage” or “MA,” that lets private health insurance companies provide Medicare benefits through an MA Plan.

**Medicare Part D:** The Medicare prescription drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

**Medicare Part D drugs:** Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

**Medication Therapy Management:** A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your *Member Handbook* for more information.

**Member (member of our plan, or plan member):** A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

**Member Handbook and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

**Member Services:** A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Member Handbook* for more information about Member Services.

**Network pharmacy:** A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Network provider:** “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

**Nursing home or facility:** A place that provides care for people who can’t get their care at home but don’t need to be in the hospital.

**Ombudsman:** An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. You can find more information in **Chapters 2 and 9** of your *Member Handbook*.

**Organization determination:** Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions.” **Chapter 9** of your *Member Handbook* explains coverage decisions.

**Original Medicare (traditional Medicare or fee-for-service Medicare):** The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don’t want to be in our plan, you can choose Original Medicare.

**Out-of-network pharmacy:** A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn’t cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

**Out-of-network provider or Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. **Chapter 3** of your *Member Handbook* explains out-of-network providers or facilities.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans that do not have cost sharing delete this paragraph.]* **Out-of-pocket costs:** The cost sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost sharing” above.

**Over-the-counter (OTC) drugs:** Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

**Part A:** Refer to “Medicare Part A.”

**Part B:** Refer to “Medicare Part B.”

**Part C:** Refer to “Medicare Part C.”

**Part D:** Refer to “Medicare Part D.”

**Part D drugs:** Refer to “Medicare Part D drugs.”

**Personal health information (also called Protected health information) (PHI):**

Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

*[Plans that do not use PCPs may omit this paragraph.]* **Primary care provider (PCP):** The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your *Member Handbook* for information about getting care from primary care providers.

**Prior authorization (PA):** *[Plans may delete applicable words or sentences if it does not require PA for any medical services or any drugs.]* An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of your *Member Handbook*.

Our plan covers some drugs only if you get PA from us.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs*.

**Program for All-Inclusive Care for the Elderly (PACE):** A program that covers Medicare and Medicaid benefits together for people age 55 and older who need a higher level of care to live at home.

**Prosthetics and Orthotics:** Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Quality improvement organization (QIO):** A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Member Handbook* for information about the QIO.

**Quantity limits:** A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

**Referral:** A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of your *Member Handbook*.

**Rehabilitation services:** Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Member Handbook* to learn more about rehabilitation services.

**Service area:** A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get our plan.

*[Insert if applicable]* **Share of cost:** The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

**Skilled nursing facility (SNF):** A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

**Skilled nursing facility (SNF) care:** Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

**Specialist:** A doctor who provides health care for a specific disease or part of the body.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**State Hearing:** If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

**Step therapy:** A coverage rule that requires you to try another drug before we cover the drug you ask for.

**Supplemental Security Income (SSI):** A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently needed care:** Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



*[Plans may add a back cover for the Member Handbook that contains contact information for Member Services. Below is an example plans may use. Plans also may add a logo and/or photographs, as long as these elements do not make it difficult for members to find and read the contact information.]*

## <Plan name> Member Services

|                |                                                                                                                                                                                                                                                                                             |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <i>[Insert phone number(s).]</i><br><br>Calls to this number are free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i><br><br>Member Services also has free language interpreter services available for non-English speakers.    |
| <b>TTY</b>     | <i>[Insert number.]</i><br><br><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i><br><br>Calls to this number are free. <i>[Insert days and hours of operation.]</i> |
| <b>FAX</b>     | <i>[Optional: Insert fax number.]</i>                                                                                                                                                                                                                                                       |
| <b>WRITE</b>   | <i>[Insert address.]</i><br><br><i>[Note: Plans may add email addresses here.]</i>                                                                                                                                                                                                          |
| <b>WEBSITE</b> | <i>[Insert URL.]</i>                                                                                                                                                                                                                                                                        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Instructions to Health Plans

- ❖ *[Plans may include the ANOC in the 2024 Member Handbook (Evidence of Coverage) or provide it to members separately.]*
- ❖ *[Plans may modify the language in the ANOC, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]*
- ❖ *[Plans must use the state-specific name for Medicaid in references to “Medicaid” in any plan-customized language throughout the ANOC.]*
- ❖ *[Throughout the document update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medicaid plans, etc.).]*
- ❖ *[Where the ANOC uses “medical care,” “medical services,” or “health care services” to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]*
- ❖ *[Plans may change references to terms such as “member,” “customer,” “beneficiary,” “enrollee,” “member services,” “care coordinator,” “primary care provider,” “prior authorization (PA)” as instructed by the state or based on plan preference and update them consistently throughout the ANOC.]*
- ❖ *[Where the model material instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]*
- ❖ *[Throughout the ANOC, plans must follow the applicable style rules of the state, if any. For instance, where the model material instructs inclusion of a date or time, plans must use the specific format requested by the state Medicaid program. Other items covered by a state-specific style guide or similar document should also be updated accordingly.]*
- ❖ *[Plans should refer to the Member Handbook as needed using the appropriate chapter number, section, and/or page number. For example, “refer to Chapter 9, Section A, page 1.” An instruction [insert reference, as applicable] appears with many cross references throughout the ANOC and Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*
- ❖ *[Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).*
- *Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.*
- *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
- *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.*
- *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
- *Avoid separating a heading or subheading from the text that follows when paginating the model.*
- *Use universal symbols or commonly understood pictorials.*
- *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
- *Consider using regionally appropriate terms or common dialects in translated models.*
- *Include instructions and navigational aids in translated models in the translated language rather than in English.*
- *Consider producing translated models in large print.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

<Plan name> [insert plan type] offered by [insert sponsor name]

# Annual Notice of Changes for 2024

[Optional: insert member name]

[Optional: insert member address]

## Introduction

[If there are any changes to the plan for 2024, insert: You are currently enrolled as a member of our plan. Next year, there will be some changes to our [insert as applicable: benefits, coverage, rules, [and] costs]. This [insert as applicable: section or Annual Notice of Changes] tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the Member Handbook, which is located on our website at [insert URL]. Key terms and their definitions appear in alphabetical order in the last chapter of your Member Handbook.]

[If there are no changes whatsoever for 2024 (e.g., no changes to benefits, coverage, rules, costs, networks), insert: You are currently enrolled as a member of our plan. Next year, there are no changes to our benefits, coverage, [and] rules [insert if applicable: and costs]. However, you should still read this [insert as applicable: section or Annual Notice of Changes] to learn about your coverage choices. To get more information about costs, benefits, or rules please review the Member Handbook, which is located on our website at [insert URL]. Key terms and their definitions appear in alphabetical order in the last chapter of your Member Handbook.]

[Any plan that does not include a particular section (e.g., Section C, Section F) deletes the section, orders all remaining sections and subsections sequentially, and updates the Table of Contents accordingly. Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

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**Commented [ES1]:** Members receive this document by September 30, but the Handbook and other member materials are not posted on the website until October 15. It would probably be helpful to make note of that here so they aren't looking for the materials before they are available.

**Commented [ES2]:** Same comment as above.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## A. Disclaimers

- ❖ *[Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidance and included in any state-specific guidance provided by <insert state>.] [Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, here.]*

## B. Reviewing your Medicare and *[Insert name of Medicaid program]* coverage for next year

It is important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section E** for more information.

If you choose to leave our plan, your membership will end on the last day of the month in which your request was made. You will still be in the Medicare and *[Insert name of Medicaid program]* programs as long as you are eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section G2** *[insert reference, as applicable]*.
- *[Insert name of Medicaid program]* services in **Section G2** *[insert reference, as applicable]*.

**Commented [ES3]:** Does this mean more information about benefits or more information about how to leave the plan?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B1. Additional resources

- ATTENTION: If you speak *[insert language of the disclaimer]*, language assistance services, free of charge, are available to you. Call *[insert Member Services toll-free phone and TTY numbers, and days and hours of operation]*. The call is free. *[This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation.]*
- You can get this *[Insert as applicable: section or Annual Notice of Changes]* for free in other formats, such as large print, braille, or audio. Call *[insert Member Services toll-free phone and TTY numbers, and days and hours of operation]*. The call is free.
- *[Plans also simply describe:*
  - *how they request a member's preferred language other than English and/or alternate format,*
  - *how they keep the member's information as a standing request for future mailings and communications so the member does not need to make a separate request each time, and*
  - *how a member can change a standing request for preferred language and/or format.]*

## B2. Information about <plan name>

- *[Insert plan's legal or marketing name]* is a health plan that contracts with both Medicare and Medicaid to provide benefits of both programs to members.
- Coverage under *[insert plan name]* is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.
- When this *Annual Notice of Changes* says "we," "us," "our," or "our plan," it means *[insert plan name]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### B3. Important things to do

- **Check if there are any changes to our benefits *[insert if applicable: and costs]* that may affect you.**
  - Are there any changes that affect the services you use?
  - Review benefit *[insert if applicable: and cost]* changes to make sure they will work for you next year.
  - Refer to **Section E1** for information about benefit *[insert if applicable: and cost]* changes for our plan.
- **Check if there are any changes to our prescription drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different *[insert if applicable: cost-sharing]* tier? Can you use the same pharmacies?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section E2** for information about changes to our drug coverage.
  - *[All plans with any Medicare Part D cost sharing insert: Your drug costs may have risen since last year.*
    - Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year.
    - Keep in mind that your plan benefits determine exactly how much your own drug costs may change.]
- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section D** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
  - *[Insert if applicable: How much will you spend out-of-pocket for the services and prescription drugs you use regularly?]*

**Commented [ES4]:** If plans have no costs for medical services but only for Part D drugs, should the "costs" part be included here?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- How do the total costs compare to other coverage options?
- **Think about whether you are happy with our plan.**

**If you decide to stay with <2024 plan name>:**

If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in <2024 plan name>.

**If you decide to change plans:**

*[Plans should revise this paragraph as necessary]* If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section G2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

---

**C. Changes to our plan name**

*[Plans that are not changing the plan name, delete this section. Plans with an anticipated name change at a time other than January 1 may modify the date below as necessary.]*

On January 1, 2024, our plan name changes from <2023 plan name> to <2024 plan name>.

*[Insert language to inform members whether they will get new plan ID cards and how, as well as how the name change affects any other member communication.]*

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**D. Changes to our network providers and pharmacies**

*[Plans with no changes to network providers and pharmacies insert: We have not made any changes to our network of providers and pharmacies for next year.]*

However, it's important that you know that we may make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook*.

*[Plans with changes to provider and/or pharmacy networks, insert: Our [insert if applicable: provider] [and] [insert if applicable: pharmacy] network[s] [insert as applicable: has or have] changed for 2024.]*

Please **review the 2024 Provider and Pharmacy Directory** to find out if your providers or pharmacy are in our network. *[An updated Provider and Pharmacy Directory is located on our*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

website at <web address>. You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook*.]

**Commented [ES5]:** Same comment as about the Member Handbook...this doc gets to members Sept 30, but the updated PPD doesn't get posted until October 15. Could that be specified here so they aren't looking for it before it's posted?

## E. Changes to benefits *[insert if applicable: and costs]* for next year

### E1. Changes to benefits *[insert if applicable: and costs]* for medical services

*[If there are no changes in benefits or in cost sharing, replace the rest of the section with: There are no changes to your benefits *[insert if applicable: or amounts you pay]* for medical services. Our benefits *[insert if applicable: and what you pay for these covered medical services]* will be exactly the same in 2024 as they are in 2023.]*

We're changing our coverage for certain medical services *[insert if applicable: and what you pay for these covered medical services]* next year. The table below describes these changes.

*[The table must include:*

- *All new benefits that will be added or 2023 benefits that will end for 2024;*
- *New or changing limitations or restrictions, including prior authorizations (PA), on benefits for 2024; and*
- *All changes in cost sharing for 2024 for covered medical services, including any changes to service category out-of-pocket maximums.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                              | 2023 (this year)                                                                                                                                                                                                                                                                                        | 2024 (next year)                                                                                                                                                                                                                                                                                           |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>[Insert benefit name]</i> | <i>[For benefits that were not covered in 2023, insert:<br/><br/>[insert benefit name] is not covered.]<br/><br/>[For benefits with a copay insert:<br/><br/>You pay a \$&lt;2023 copay amount&gt; copay [insert language as needed to accurately describe the benefit, e.g., "per office visit"].]</i> | <i>[For benefits that will not be covered in 2024, insert:<br/><br/>[insert benefit name] is not covered.]<br/><br/>[For benefits with a copay insert:<br/><br/>You pay a \$&lt;2024 copay amount&gt; copay [insert language as needed to accurately describe the benefit, e.g., "per office visit"].]</i> |
| <i>[Insert benefit name]</i> | <i>[Insert 2023 cost or coverage, using format described above.]</i>                                                                                                                                                                                                                                    | <i>[Insert 2024 cost or coverage, using format described above.]</i>                                                                                                                                                                                                                                       |

**E2. Changes to prescription drug coverage**

**Changes to our Drug List**

*[Plans that did not include a List of Covered Drugs in the envelope, insert: You will get a 2024 List of Covered Drugs in a separate mailing.]*

*[Plans that did not include a List of Covered Drugs in the envelope and will not mail it separately unless requested, insert: An updated List of Covered Drugs is located on our website at <web address>. You may also call Member Services at the numbers at the bottom of the page for updated drug information or to ask us to mail you a List of Covered Drugs.]*

*[Plans that included a List of Covered Drugs in the envelope, insert: We sent you a copy of our 2024 List of Covered Drugs in this envelope.] The List of Covered Drugs is also called the "Drug List."*

*[Plans with no changes to covered drugs, tier assignment, or restrictions may replace the rest of this section with: We have not made any changes to our Drug List for next year. However, we are allowed to make changes to the Drug List from time to time throughout the year, with approval from Medicare and/or the state. Refer to the 2024 Drug List for more information.]*

**Commented [ES6]:** Same comment. Could we make note that it's available as of October 15?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs.

Review the Drug List to **make sure your drugs will be covered next year** and to find out if there are any restrictions.

If you are affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
  - You can call Member Services at the numbers at the bottom of the page [\[insert if applicable: or contact your care coordinator\]](#) to ask for a list of covered drugs that treat the same condition.
  - This list can help your provider find a covered drug that might work for you.
- [\[Plans should include the following language if they have an advance transition process for current members:\]](#) Work with your doctor (or other prescriber) and ask us to make an exception to cover the drug.
  - You can ask for an exception before next year, and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement).
  - To learn what you must do to ask for an exception, refer to **Chapter 9** of your *Member Handbook* or call Member Services at the numbers at the bottom of the page.
  - If you need help asking for an exception, contact Member Services [\[insert if applicable: or your care coordinator\]](#). Refer to **Chapters 2 and 3** of your *Member Handbook* to learn more about how to contact your care coordinator.
- [\[Plans should include the following language if all current members will not be transitioned in advance for the following year:\]](#) Ask us to cover a temporary supply of the drug.
  - In some situations, we cover a **temporary** supply of the drug during the first [\[must be at least 90\]](#) days of the calendar year.
  - This temporary supply is for up to [\[insert supply limit \(must be the number of days in plan's one-month supply\)\]](#) days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
  - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

different drug our plan covers or ask us to make an exception for you and cover your current drug.

*[Plans may include additional information about processes for transitioning current enrollees to formulary drugs when your formulary changes relative to the previous plan year.]*

*[Include language to explain whether current formulary exceptions will still be covered next year or a new one needs to be submitted.]*

**Changes to prescription drug costs** *[option for plans with two drug payment stages]*

*[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), should include the following information in the ANOC.]*

*[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]*

There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

| Stage 1<br>Initial Coverage Stage                                                                                                                                                                        | Stage 2<br>Catastrophic Coverage Stage                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay.<br><br>You begin this stage when you fill your first prescription of the year. | During this stage, the plan pays all of the costs of your drugs through December 31, 2024.<br><br>You begin this stage after you pay a certain amount of out-of-pocket costs. |

The Initial Coverage Stage ends when your total out-of-pocket costs for prescription drugs reaches *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you will pay for prescription drugs.

**Commented [ES7]:** How should plans determine which of these to use?

**E3. Stage 1: “Initial Coverage Stage”**

During the Initial Coverage Stage, our plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Insert if applicable: We moved some of the drugs on our Drug List to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our Drug List.]*

The following table shows your costs for drugs in each of our *[insert number of tiers]* drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

*[Plans must list all drug tiers in the following table.]*

|                                                                                                                                                                                                                           | 2023 (this year)                                                                                                                                           | 2024 (next year)                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |

The Initial Coverage Stage ends when your total out-of-pocket costs reach *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point the Catastrophic Coverage Stage begins. The plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information *about* how much you pay for prescription drugs.

**Commented [ES8]:** Missing word.

**Commented [ES9]:** Is this sentence necessary? The chart above tells them how much they pay.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**E4. Stage 2: “Catastrophic Coverage Stage”**

When you reach the out-of-pocket limit *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]* for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year.

- *[Plans that do not reduce the copays for [insert name of the Medicaid program]-covered drugs in the catastrophic coverage stage should insert the following language: To locate more information about your prescriptions that Medicare and [insert name of the Medicaid program] cover, refer to the List of Covered Drugs, [insert reference, as applicable].]*

**Changes to prescription drug costs** *[option for plans with a single payment stage]*

*[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following information.]*

*[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]*

*[Insert if applicable: We moved some of the drugs on the Drug List to a lower or higher drug tier. [Insert if applicable: If your drugs move from tier to tier, this could affect your copay.] To find out if your drugs are in a different tier, look them up in the Drug List.]*

The following table shows your costs for drugs in each of our *[insert number of tiers]* drug tiers.

*[Plans must list all drug tiers in the following table.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                           | 2023 (this year)                                                                                                                                           | 2024 (next year)                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |

**F. Administrative changes**

*[Insert this section if applicable. Plans with administrative changes that impact members (e.g., change in contract or PBP number) may insert this section, include an introductory sentence that explains the general nature of administrative changes, and describe the specific changes in the table below. Plans that choose to omit this section should renumber the remaining sections as needed.]*

|                                                                                   | 2023 (this year)                                | 2024 (next year)                                |
|-----------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <i>[Insert a description of the administrative process/item that is changing]</i> | <i>[Insert 2023 administrative description]</i> | <i>[Insert 2024 administrative description]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



|                                                                                   | 2023 (this year)                                | 2024 (next year)                                |
|-----------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <i>[Insert a description of the administrative process/item that is changing]</i> | <i>[Insert 2023 administrative description]</i> | <i>[Insert 2024 administrative description]</i> |

## G. Choosing a plan

### G1. Staying in our plan

We hope to keep you as a plan member. You do not have to do anything to stay in our plan. If you do **not** change to another Medicare plan or change to Original Medicare, you automatically stay enrolled as a member of our plan for 2024.

### G2. Changing plans

*[Plans should add any additional Medicaid information as directed by the state.]* Most people with Medicare can end their membership during certain times of the year. Because you have *[Insert name of Medicaid program]*, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You moved out of our service area,
- Your eligibility for *[Insert name of Medicaid Program]* or Extra Help changed, **or**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

**Your Medicare services**

You have three options for getting your Medicare services. By choosing one of these options, you automatically end your membership in our plan. *[Insert additional option to change to another integrated program as directed by the state.]*

|                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>1. You can change to:</b></p> <p><b>Another Medicare health plan</b> <i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>For PACE inquiries, call 1-855-921-PACE (7223).</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call the <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i> For more information or to find a local <i>[insert name of SHIP office]</i> office in your area, please visit <i>[insert website address]</i>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare plan.</p> <p>You will automatically be disenrolled from our plan when your new plan’s coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
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| <p><b>2. You can change to:</b></p> <p><b>Original Medicare with a separate Medicare prescription drug plan</b></p> <p><i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i> For more information or to find a local <i>[insert name of office]</i> office in your area, please visit <i>[insert website address]</i>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare prescription drug plan.</p> <p>You will automatically be disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>3. You can change to:</b></p> <p><b>Original Medicare without a separate Medicare prescription drug plan</b></p> <p><i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> <p><b>NOTE:</b> If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join.</p> <p>You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i></li></ul> <p>You will automatically be disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Your *[insert name of state Medicaid program]* services**

For questions about how to get your *[insert name of Medicaid program]* services after you leave our plan, contact *[insert name of program, phone number, days and hours of operation, and TTY number and website if applicable]*. Ask how joining another plan or returning to Original Medicare affects how you get your *[insert name of Medicaid program]* coverage.

**Commented [ES10]:** Is this the name of the Medicaid program?

**H. Getting help**

**H1. Our plan**

We're here to help if you have any questions. Call Member Services at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

**Read your *Member Handbook***



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits *[insert if applicable: and costs]* for 2024. It explains your rights and the rules to follow to get services and prescription drugs we cover.

*[If the ANOC is sent or provided separately from the Member Handbook, include the following: The Member Handbook for 2024 will be available by October 15.] [Insert if applicable: You can also review the <attached or enclosed or separately mailed> Member Handbook to find out if other benefit [insert if applicable: or cost] changes affect you.]* An up-to-date copy of the *Member Handbook* is available on our website at *<web address>*. You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2024.

#### **Our website**

You can visit our website at *<web address>*. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our Drug List (*List of Covered Drugs*).

#### **H2. *[Insert name of the State Health Insurance Assistance Program (SHIP)]***

You can also call the State Health Insurance Assistance Program (SHIP). In *[Insert name of state]* the SHIP is called the *[Insert name of program]*. *[Insert name of program staff]* can help you understand your plan choices and answer questions about switching plans. *[Insert name of program]* HICAP is not connected with us or with any insurance company or health plan. *[Insert name of program]* has trained counselors *[insert in every county or locations]* and services are free. *[Insert name of program]* phone number is *[TTY phone number is optional.]* For more information or to find a local *[Insert name of program]* office in your area, please visit *[insert website address]*.

Commented [ES11]: What is HICAP? Should this say SHIP?

#### **H3. *[Insert State-specific name for ombudsman program]***

*[Insert this section if there is an ombudsman program in the state. Include a description of what the program can do, whether the services are free, and phone number. Please refer to an example of language below.]*

*[Optional language example: The Ombudsman Program can help you if you have a problem with our plan. The ombudsman's services are free and available in all languages. The Ombudsman Program:*

- Works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do.*
- Makes sure you have information related to your rights and protections and how you can get your concerns resolved.*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Is not connected with us or with any insurance company or health plan. The phone number for the Ombudsman Program is [insert phone number].*

#### H4. Medicare

To get information directly from Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**Commented [ES12]:** Should it be noted that the calls are free?

##### Medicare's Website

You can visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to [www.medicare.gov](http://www.medicare.gov) and click on "Find plans.")

##### Medicare & You 2024

You can read the *Medicare & You 2024* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf](http://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf)) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**Commented [ES13]:** Same comment as above.

*[Insert any additional sections as required by the state, such as the QIO or additional resources that might be available.]*

#### H5. *[Insert state-specific name of Medicaid program.]*

*[Insert a description of the state Medicaid program's role and how to receive assistance from the state.]*

#### H6. *[Insert additional resources if applicable]*

*[If applicable, insert a new section for each additional resource, including contact information and a description of their role.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## <Plan name> *Member Handbook*

- ❖ *[Plans may add a front cover to the Member Handbook that contains information such as the plan name, Member Handbook title, and contact information for Member Services. Plans may add a logo and/or photographs to the front cover as long as these elements do not make it difficult for members to read other information on the cover. If plans add a front cover, it must contain the Material ID.]*
- ❖ *[Plans must use the state-specific name for Medicaid in references to “Medicaid” in any plan-customized language throughout the Member Handbook.]*
- ❖ *[Plans may modify the language in the Member Handbook, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]*
- ❖ *[Throughout the document plans should update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medicaid plans, etc.)]*
- ❖ *[Where the Member Handbook uses “medical care,” “medical services,” or “health care services” to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]*
- ❖ *[Plans may change references to terms such as “member,” “customer,” “beneficiary,” “member services,” “health risk assessment,” “care coordinator,” “primary care provider,” “prior authorization (PA),” “nursing facility”, and “urgently needed care”, etc. as instructed by the state or based on plan preference and update them consistently throughout the Member Handbook.]*
- ❖ *[Where the model material instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]*
- ❖ *[Throughout the Member Handbook, in addition to following all Medicare and Medicaid requirements in regulation and the Medicare Communications and Marketing Guidelines, plans must follow additional applicable style rules of the state, if any.]*
- ❖ *[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number as appropriate. For example, “refer to Chapter 9, Section A, page 1.” An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*
- ❖ *[Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:]*

**Commented [ES1]:** Having the Handbook broken into chapters rather than combined into one document is problematic because it does not allow for searching the entire document at once unless the chapters are combined. For the sake of consistency when replacing terms or variables, it's important to be able to search the entire document. There are also issues with the TOCs for each chapter (noted later in this doc). When combining the chapters, the section letters often default to continuing the lettering from the previous chapter, forcing manual corrections for the section letters. These then need to be double checked several times to ensure that the formatting holds, because changes in one area of the document can cause reversions or updates in previous parts of the document. It would be preferable to receive this document in one piece rather than separate chapters, as we do for other member materials.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).*
- *Ensure plan-customized text is in plain language and complies with reading level requirements established in by the state.*
- *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
- *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.*
- *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
- *Avoid separating a heading or subheading from the text that follows when paginating the model.*
- *Use universal symbols or commonly understood pictorials.*
- *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
- *Consider using regionally appropriate terms or common dialects in translated models.*
- *Include instructions and navigational aids in translated models in the translated language rather than in English.*
- *Consider producing translated models in large print.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



<start date> – <end date>

## Your Health and Drug Coverage under <plan name>

[Plans: Revise this language to reflect that the organization is providing both Medicaid and Medicare covered benefits, when applicable.]

[Optional: Insert member name.]

[Optional: Insert member address.]

### Member Handbook Introduction

This *Member Handbook*, otherwise known as the *Evidence of Coverage*, tells you about your coverage under our plan through <end date>. It explains health care services [plans may add references to other behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports, as needed]. Key terms and their definitions appear in alphabetical order in Chapter 12 of your *Member Handbook*.

**This is an important legal document. Keep it in a safe place.**

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means [insert plan name].

ATTENTION: If you speak [insert language of the disclaimer], free language assistance services are available to you. Call <plan name> Member Services at the number at the bottom of this page. The call is free. [This disclaimer must be included in all non-English languages that meet the Medicare or state thresholds for translation.]

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

[Plans also simply describe:

- how they request a member's preferred language other than English and/or alternate format,
- how they keep the member's information as a standing request for future mailings and communications so the member does not need to make a separate request each time, **and**
- how a member can change a standing request for preferred language and/or format.]

[Plans must include an overall Table of Contents for the Member Handbook after the Member Handbook Introduction and before the Member Handbook Disclaimers.]

**Commented [ES2]:** This is somewhat problematic as this must be done manually. The way the styles and other TOCs in the Handbook are set up, it is not possible to use the auto update feature for TOCs once all of the chapters are combined.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Disclaimers

- ❖ *[Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidelines, and included in any state-specific guidance.]*
- ❖ *[Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, [here](#).]*
- ❖ Coverage under *[insert plan name]* is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 1: Getting started as a member

### Introduction

This chapter includes information about *[insert plan name]*, a health plan that *[insert description of the relationship such as covers or coordinates]* all of your Medicare and *[insert name of Medicaid program]* services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

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**Commented [ES3]:** The TOCs throughout the Handbook are problematic. Once the chapters are combined into one document (necessary to properly paginate) these TOCs can no longer be auto-updated because each one will list all of the headings for the entire document rather than the specific chapter. If you choose only to update the page numbers, it works sometimes—but other times it auto updates the entire table without asking if you want to only update the page numbers. Regardless, the chapter sections and headings in the TOCs **must** be updated manually, which increases the risk of error.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Welcome to our plan

*[Insert language to describe the relationship between the Medicare and Medicaid services. For example: Our plan provides Medicare and [insert name of Medicaid program] services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.]*

*[Plan can include language about itself.]*

**Commented [ES4]:** Should this be "covers"? "Includes" makes it sound as if the doctors and other providers are a part of our plan, rather than a part of our plan's network. I.e., the plan and the providers are separate entities.

## B. Information about Medicare and [Insert name of Medicaid Program]

### B1. Medicare

Medicare is the federal health insurance program for:

- People 65 years of age or older,
- Some people under age 65 with certain disabilities, **and**
- People with end-stage renal disease (kidney failure).

**Commented [ES5]:** Could the word "over" be used here instead? Our members prefer not to be referred to as "older."

### B2. [Insert name of Medicaid Program]

*[Insert name of the Medicaid program]* is the name of *[insert name of state]* Medicaid program. *[Insert name of Medicaid program]* is run by the state and is paid for by the state and the federal government. *[Insert name of Medicaid program]* helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- What counts as income and resources,
- Who is eligible,
- What services are covered, **and**
- The cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

*[Plans should revise this section to best reflect the coverage of the plan.]* Medicare and the state of *[insert name of state]* approved our plan. You can get Medicare and *[insert name of state Medicaid program]* services through our plan as long as:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We choose to offer the plan, **and**
- Medicare and the State of *[insert name of state]* allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and *[insert name of state program]* services is not affected.

---

## C. Advantages of our plan

*[Plans should revise this section to best reflect the coverage of the plan.]* You will now get all your covered Medicare and *[Insert name of Medicaid program]* services from our plan, including prescription drugs. **You do not pay extra to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **all** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

---

## D. Our plan's service area

*[Insert plan service area here or within an appendix. Include a map if one is available.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Use county name only if approved for entire county, for example: Our service area includes these counties in <State>: <counties>.*

*For an approved partial county, use county name plus approved ZIP code(s) that are excluded, for example: Our service area includes all parts of <county> with the exception of the following ZIP code(s): <ZIP code(s)>.*

*If needed, plans may insert a table with more than one row or a short, bulleted list to describe and illustrate their service area in a way that is easy to understand.]*

Only people who live in our service area can join our plan.

**You cannot stay in our plan if you move outside of our service area.** Refer to **Chapter 8** of your *Member Handbook* for more information about the effects of moving out of our service area.

---

## E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- Live in our service area, **and**
- Have both Medicare Part A and Medicare Part B, **and**
- *Are currently eligible for [insert name of state Medicaid program], and*
- *[Insert any Medicaid requirements], and*
- Are a United States citizen or are lawfully present in the United States.

If you lose eligibility but can be expected to regain it within *[Insert number 1-6. Plans may choose any length of time from one to six months for deeming continued eligibility, as long as they apply the criteria consistently across all members and fully inform members of the policy.]* month(s), then you are still eligible for our plan.

Call Member Services for more information.

---

## F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date *[Plans adjust this language if the state requirement is more stringent]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs [\[add additional areas covered by HRA\]](#).

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

*[Plans may add additional language regarding information about joining the plans as directed by the state such as information about a continuity of care period or using doctors for a transition period.]*

---

## G. Your care team and care plan

### G1. Care team

A care team can help you keep getting the care you need. A care team may include your **doctor**, a care coordinator, or other health person that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

### G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your **doctors** what services you need and how to get them. It includes your medical, behavioral health, and [\[Insert as applicable: LTSS or other services\]](#).

Your care plan includes: [\[Update the description of the care plan and the process as outlined in your model of care \(MOC\)\]](#).

- Your health care goals.
- A timeline for getting the services you need.

Your care team meets with you after your health risk assessment. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

**Commented [E56]:** Can plans use health care provider or primary care provider instead? We have many mid-level providers (NPs, PAs, etc.) who are not doctors who provide services for our members.

**Commented [E57]:** Again, health care providers? This comment applies here and in most places throughout the Handbook (except where a physician is specifically required).



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## H. Your monthly costs for *[insert plan name]*

*[Plans should revise this section to only include premium types that apply or delete if plan has no monthly premium and revise with “Our plan has no premium.”]*

Your costs may include the following:

- Plan premium (Section H.1)
- Monthly Medicare Part B Premium (Section H.2)
- Optional Supplemental Benefit Premium (Section H.3)

**In some situations, your plan premium could be less.**

*[Insert as appropriate, depending on whether SPAPs are discussed in Chapter 2: There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. OR The “Extra Help” program helps people with limited resources pay for their drugs.]* Chapter 2, Section H2 tells more about *[insert as applicable: these programs OR this program.]* If you qualify, enrolling in the program might lower your monthly plan premium.

If you *already enrolled* and are getting help from one of these programs, **the information about premiums in this *Member Handbook*** *[insert as applicable: may OR does]* **not apply to you.** *[If not applicable, omit information about the LIS Rider.]* We *[insert as appropriate: have included OR sent you]* a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

### H1. Plan premium

*[If applicable, plans should revise this section to indicate that the plan premium is paid on behalf of members (e.g. by “Extra Help”, Medicaid).]*

As a member of your plan, you pay a monthly plan premium. *[Select one of the following: For 2024, the monthly premium for *[insert 2024 plan name]* is *[insert monthly premium amount]*. OR The monthly premium amount for *[insert 2024 plan name]* is listed in *[describe attachment.]* *[Plans may insert a list or table with the state/region and monthly plan premium amount for each area included within the EOC. Plans may also include premium(s) in an attachment to the EOC.]**

*[Plans with no premium should delete this section.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H2. Monthly Medicare Part B Premium

### Many members are required to pay other Medicare premiums

*[Plans that include a Medicare Part B premium reduction benefit may describe the benefit within this section.]*

*[Plans that do not have any members paying Medicare premiums or plans whose members must pay the full Medicare Part B premium should modify this section.]*

*[Plans with no monthly premium, omit: In addition to paying the monthly plan premium,]* some members are required to pay other Medicare premiums. As explained in **Section H2 above**, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most *[insert 2024 plan name]* members, Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and for your Medicare Part B premium.

**If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.** This includes your premium for Medicare Part B. It may also include a premium for Medicare Part A which affects members who aren't eligible for premium free Medicare Part A. **In addition, please contact Member Services or your care coordinator and inform them of this change.**

### H3. Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called "optional supplemental benefits," then you pay additional premium each month for these extra benefits. Refer to Chapter 4, Section E for details. *[If the plan describes optional supplemental benefits within Chapter 4, then the plan must include the premium amounts for those benefits in this section.]*

**Commented [ES8]:** Is this the wrong section reference? This is H2.

**Commented [ES9]:** Can this section be deleted if plans don't have optional supplemental benefits?

## I. Your Member Handbook

Your *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* found on our website *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

The contract is in effect for the months you are enrolled in our plan between *[insert start date]* and *[insert end date]*.

**Commented [ES10]:** Should this say that the call is free? Also, should TTY number be included?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, *[insert if applicable: information about how to access]* a *Provider and Pharmacy Directory*, *[plans that limit DME brands and manufacturers insert: a List of Durable Medical Equipment,]* and *[insert if applicable: information about how to access]* a *List of Covered Drugs*, also known as a *Formulary*.

### J1. Your Member ID Card

Under our plan, you have one card for your Medicare and *[insert name of Medicaid program]* services, including long-term services and supports, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:

*[Insert picture of front and back of plan ID card. Mark it as a sample card (for example, by superimposing the word "sample" on the image of the card).]*

If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your *[insert name of Medicaid program]* card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Member Handbook* to find out what to do if you get a bill from a provider.

*[If members must use a different card for any Medicaid services, include a description here.]*

### J2. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Provider and Pharmacy Directory* at *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

*[Plans must add information describing the information available in the directory.]*

*[Plans may add information describing the use of providers during a transition period as directed by the state.]*

**Commented [ES11]:** Would it be possible to add an optional "most" in between get and services here? Re: the direction below for plans to include a separate description if there are Medicaid services members must use a different card for, it is possible and may confuse members if we state this here without the qualifier "most".



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Definition of network providers**

- Our network providers include:
  - Doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - LTSS, behavioral health services, home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

**Definition of network pharmacies**

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to [\[insert if applicable: help you\]](#) pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

[\[Plans that limit DME brands and manufacturers insert the following section \(for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual:](#)

**List of Durable Medical Equipment (DME)**

We sent you our List of Durable Medical Equipment (DME) with this *Member Handbook*. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at the address at the bottom of the page. Refer to **Chapters 3 and 4** of your *Member Handbook* to learn more about DME equipment.]

**J3. List of Covered Drugs**

The plan has a *List of Covered Drugs*. We call it the “Drug List” for short. It tells you which prescription drugs our plan covers.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Member Handbook* for more information.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Each year, we send you [\[insert if applicable: information about how to access\]](#) the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website [at the address at the bottom of the page](#). [\[Plans may insert information about Medicaid covered drugs.\]](#)

#### J4. The Explanation of Benefits

When you use your Medicare Part D prescription drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D prescription drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take [\[insert, as applicable: such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options\]](#).

**Chapter 6** of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

[\[Plans may insert other methods for members to get their EOB.\]](#)

---

## K. Keeping your membership record up to date

[\[In the Table of Contents, section heading, and text, plans substitute the name for this file if it differs from "membership record."\]](#)

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you.**

Tell us right away about the following:

- Changes to your name, your address, or your phone number.
- Changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation.
- Any liability claims, such as claims from an automobile accident.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Admission to a nursing facility or hospital.
- Care from a hospital or emergency room.
- Changes in your caregiver (or anyone responsible for you.)
- You take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

*[Plans that allow members to update this information online may describe that option here.]*

*[Plans may add information regarding keeping their Medicaid information updated as directed by the state.]*

### **K1. Privacy of personal health information (PHI)**

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.*

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<Plan name> MEMBER HANDBOOK

## Chapter 2: Important phone numbers and resources

### Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[If applicable, plans should modify this chapter to include contact information for other resources.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## A. Member Services

|                |                                                                                                                                                                                                                                                                       |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <Phone number(s)> This call is free.<br><br><Days and hours of operation> <i>[Include information on the use of alternative technologies.]</i><br><br>We have free interpreter services for people who do not speak English.                                          |
| <b>TTY</b>     | <TTY phone number> This call is free.<br><br><i>[Insert if the plan uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i><br><br><Days and hours of operation> |
| <b>FAX</b>     | <i>[Fax number is optional.]</i>                                                                                                                                                                                                                                      |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                                                                     |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                                   |
| <b>WEBSITE</b> | <i>[Web URL.]</i>                                                                                                                                                                                                                                                     |

Contact Member Services to get help with:

- Questions about the plan
- Questions about claims or billing

*[If plans have different numbers for the functions listed below, plans should insert separate charts with the additional contact information.]*

- Coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of your *Member Handbook* or contact Member Services.
- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (refer to **Section F** *[insert reference, as applicable]*).
  - You can call us and explain your complaint at <phone number>.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above *[insert reference, as applicable]*).
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - *[Insert additional instructions regarding how to make a complaint as directed by the state.]*
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Member Handbook*.
- Coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**
    - the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs *[insert if applicable, and name of Medicaid program prescription drugs and over-the-counter drugs]*.
  - For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above *[insert reference, as applicable]*.)
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Payment for health care or drugs you already paid for

*[Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]*

  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of your *Member Handbook*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B. Your Care Coordinator

*[Plans should include information explaining what a care coordinator is, how members can get a care coordinator, how they can contact the care coordinator, and how they can change their care coordinator. Plans can modify this section as appropriate.]*

|                |                                                                                                                                                                                                                                                                                                                             |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <p>&lt;Phone number(s)&gt; This call is free.</p> <p>&lt;Days and hours of operation&gt; <i>[Include information on the use of alternative technologies.]</i></p> <p>We have free interpreter services for people who do not speak English.</p>                                                                             |
| <b>TTY</b>     | <p>&lt;TTY phone number&gt; This call is <i>[insert if applicable: not]</i> free.</p> <p><i>[Insert if the plan uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i></p> <p>&lt;Days and hours of operation&gt;</p> |
| <b>FAX</b>     | <i>[Fax number is optional.]</i>                                                                                                                                                                                                                                                                                            |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                                                                                                                           |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                                                                                         |
| <b>WEBSITE</b> | <i>[Web address is optional.]</i>                                                                                                                                                                                                                                                                                           |

Contact your care coordinator to get help with:

- Questions about your health care
- Questions about getting behavioral health (mental health and substance use disorder) services
- Questions about transportation
- Questions about long-term services and supports (LTSS). LTSS includes *[Plans should insert information describing LTSS coverage.]*
- *[Plans may insert bullets noting additional areas that care coordinators can provide assistance with.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### C. *[Insert State-specific Name of SHIP Program]*

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In *<insert state>*, the SHIP is called *<State-specific SHIP name>*.

*<Insert state-specific SHIP name>* is not connected with any insurance company or health plan.

**Commented [BW1]:** Our state currently offers contact information for additional resources before the SHIP, such as a nurse advice line and a behavioral health crisis line. While these could be moved to Section J instead, we believe the flow of the document and their relative importance warrant placement just after the care coordinator.

|         |                                                                                                                                                                                                                               |
|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CALL    | <i>&lt;Phone number(s)&gt;</i><br><i>&lt;Days and hours of operation&gt;</i>                                                                                                                                                  |
| TTY     | <i>[TTY phone number is optional.]</i><br><i>[Insert if the SHIP uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| WRITE   | <i>&lt;Mailing address&gt;</i>                                                                                                                                                                                                |
| EMAIL   | <i>[Email address is optional.]</i>                                                                                                                                                                                           |
| WEBSITE | <i>&lt;Web address&gt;</i>                                                                                                                                                                                                    |

Contact *<insert name of SHIP program>* for help with:

- Questions about Medicare
- *<State-specific SHIP name>* counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.



**If you have questions**, please call *<plan name>* at *<toll-free phone and TTY numbers>*, *<days and hours of operation>*. The call is free. **For more information**, visit *<web address>*.

## D. Quality Improvement Organization (QIO)

Our state has an organization called <State-specific QIO name>. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. <State-specific QIO name> is not connected with our plan.

|                |                                                                                                                                                                                                                              |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <Phone number(s)>                                                                                                                                                                                                            |
| <b>TTY</b>     | <i>[TTY phone number is optional.]</i><br><i>[Insert if the QIO uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                            |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                          |
| <b>WEBSITE</b> | <Web address>                                                                                                                                                                                                                |

Contact <State-specific QIO name> for help with:

- Questions about your health care rights
- Making a complaint about the care you got if you:
  - have a problem with the quality of care,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## E. 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, or CMS.

|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free, 24 hours a day, 7 days a week.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>TTY</b>     | 1-877-486-2048 This call is free.<br>This number is for people who have difficulty with hearing or speaking.<br>You must have special telephone equipment to call it.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>WEBSITE</b> | <a href="https://www.medicare.gov">medicare.gov</a><br>This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices.<br>It includes helpful websites and phone numbers. It also has documents you can print right from your computer.<br>If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you. |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## F. *[Insert name of Medicaid Program]*

*[Plans must adapt this generic discussion of Medicaid to reflect the name or features of the Medicaid program in the plan's state or states.]*

*[If there are two different agencies handling eligibility and coverage/services, the plan should include both and clarify the role of each.]*

*[Plans must, as appropriate, include additional telephone numbers for Medicaid program assistance.]*

***[Insert name of Medicaid program]*** Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call <State-specific Medicaid agency>.

*[If applicable, plans may also inform members that they can get information about Medicaid from county resource centers and indicate where members can find contact information for these centers.]*

**Commented [BW2]:** We would prefer to have the state-specific name written out in the first instance of the text as well as the title, if possible.

|                |                                                                                                                                                                                                                                                          |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <i>[Insert state-specific Medicaid agency]</i><br><Days and hours of operation>                                                                                                                                                                          |
| <b>TTY</b>     | <i>[Insert number, if available. Or delete this row.] [Insert if the state Medicaid program uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| <b>WRITE</b>   | <Insert Mailing address>                                                                                                                                                                                                                                 |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                      |
| <b>WEBSITE</b> | <a href="http://www.healthcareoptions.dhcs.ca.gov/">www.healthcareoptions.dhcs.ca.gov/</a><br><Insert Web URL>                                                                                                                                           |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



**G. *[Insert State-specific name for ombudsman program]***

The *<State-specific name for ombudsman program>* works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. *<State-specific name for ombudsman program>* also helps you with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

|                |                                                                                                                                                                                                                                            |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <Phone number(s)><br><Days and hours of operation>                                                                                                                                                                                         |
| <b>TTY</b>     | <i>[TTY phone number is optional.]</i><br><i>[Insert if the ombudsman program uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| <b>WRITE</b>   | <Insert Mailing address>                                                                                                                                                                                                                   |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i><br><a href="mailto:">mailto:</a>                                                                                                                                                                       |
| <b>WEBSITE</b> | <Insert Web URL><br><a href="http://www.dhcs.ca.gov/services/medicaid/Pages/MMCDOfficeoftheOmbudsman.aspx">www.dhcs.ca.gov/services/medicaid/Pages/MMCDOfficeoftheOmbudsman.aspx</a>                                                       |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H. Programs to Help People Pay for Their Prescription Drugs

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

### H1. Extra Help

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything to get this “Extra Help.”

|                |                                                                                                                                                                       |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free, 24 hours a day, 7 days a week.                                                                      |
| <b>TTY</b>     | 1-877-486-2048 This call is free.<br>This number is for people who have difficulty with hearing or speaking.<br>You must have special telephone equipment to call it. |
| <b>WEBSITE</b> | <a href="https://www.medicare.gov">medicare.gov</a>                                                                                                                   |

*[Plans that have no drug cost sharing may delete this section.]*

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your correct copayment level, or if you already have the evidence, to provide this evidence to us.

- [Plans should insert process for allowing members to request assistance with obtaining best available evidence, and for providing this evidence.]*
- [Plans should update this description to accurately reflect the process in this bullet.]* When we receive the evidence showing your copayment level, we will update our system so that you will be charged the correct copayment when you get your next prescription. If you overpay your copayment, we will pay you back. Either we will send a check to you or we will deduct the amount from future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owned by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H2. State Pharmaceutical Assistance Program (SPAP) *[Plans in states without an SPAP or where the SPAP excludes enrollment of dual eligible individuals should delete this section.]*

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Medicare Part D drugs (other than “Extra Help” you still get the 70 percent discount on covered brand name drugs. Also, the plan pays five percent of the cost of brand drugs in the coverage gap. The 70 percent discount and the five percent paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

## H3. AIDS Drug Assistance Program (ADAP)

*[Plans should delete this section if not applicable.]* The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance *[insert state-specific ADAP information.]* Note: to be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of the State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance For information on eligibility criteria, covered drugs, or how to enroll in the program, please call *[insert state-specific ADAP contact information.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## I. Social Security

Social Security determines eligibility and handles enrollment for Medicare. U.S Citizens and lawful permanent residents who are 65 and older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

|                |                                                                                                                                                                                                                                  |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-772-1213<br>Calls to this number are free.<br>Available 8:00 am to 7:00 pm, Monday through Friday.<br>You can use their automated telephone services to get recorded information and conduct some business 24 hours a day. |
| <b>TTY</b>     | 1-800-325-0778<br>This number is for people who difficulty with hearing or speaking. You must have special telephone equipment to call it.                                                                                       |
| <b>WRITE</b>   | <Insert Mailing address>                                                                                                                                                                                                         |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i><br><a href="mailto:">mailto:</a>                                                                                                                                                             |
| <b>WEBSITE</b> | <a href="http://www.ssa.gov">www.ssa.gov</a>                                                                                                                                                                                     |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## J. Other resources

*[Plans may insert this section to provide additional information resources, such as county aging and disability resource centers, choice counselors, or area agencies on aging or any other sections as directed by the state. Plans should format consistently with other sections, include a brief description and information about any other resources they add, and update the Table of Contents.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.

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<Plan name> MEMBER HANDBOOK

## Chapter 3: Using our plan's coverage for your health care and other covered services

### Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you are billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number as appropriate. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 2

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## A. Information about services and providers

**Services** are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and long-term services and supports (LTSS) are in **Chapter 4** of your *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of your *Member Handbook*.

**Commented [BW1]:** We believe it would be clearer to introduce the acronym the first time the term is used....

**Commented [BW2]:** ...rather than including it here.

**Providers** are doctors, nurses, and other people who give you services and care. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain long-term services and supports (LTSS).

**Network providers** are providers who work with our plan. These providers agree to accept our payment *[insert if plan has cost sharing: and your cost sharing amount]* as full payment. *[Plans may delete the next sentence if it is not applicable.]* Network providers bill us directly for care they give you. When you use a network provider, you usually pay *[insert as applicable: nothing or only your share of the cost]* for covered services.

## B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and *[Insert name of state-specific Medicaid program]*. This includes behavioral health and long-term services and supports (LTSS).

Our plan will generally pay for health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be a **plan benefit**. This means we include it in our Benefits Chart in **Chapter 4** of your *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise the state-specific definition of "medically necessary" as appropriate and ensure that it is updated and used consistently throughout member material models.]*
- *[Plans may omit or edit the PCP-related bullets as necessary, including modifying the name of the PCP.]* For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another doctor. As a plan member, you must choose a network provider to be your PCP.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- In most cases, *[insert as applicable: your network PCP or our plan]* must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services. To learn more about referrals, refer to page <page number>.
- *[Insert if applicable: Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is [insert definition].]*
- You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, refer to section D1 in this chapter).
- **You must get your care from network providers** *[insert if applicable: that are affiliated with your PCP's medical group]*. Usually, we won't cover care from a provider who doesn't work with our health plan *[insert if applicable: and your PCP's medical group]*. This means that you will have to pay the provider in full for the services furnished. Here are some cases when this rule does not apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to section H in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. *[Plans may specify whether authorization should be obtained before seeking care.]* In this situation, we cover the care *[insert as applicable: as if you got it from a network provider or at no cost to you]*.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility. *[Insert as applicable: The cost sharing you pay for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from an out-of-network provider the cost sharing for the dialysis may be higher.]*

*[Plans add additional exceptions as appropriate including exceptions as required by the state.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## C. Your care coordinator

*[Plans provide applicable information about the care coordinator and care coordination, as well as explanations for the following subsections. Plans should replace the terms “care coordinator” and “care team” with terms they use. If Plans use more than one type of “care coordinator,” multiple descriptions can be provided that describe each type, or additional language can be added to the care coordinator definition below.]*

### C1. What a care coordinator is

*[Example text: A care coordinator is a trained person who works for our plan to provide care coordination services for you.]*

### C2. How you can contact your care coordinator

### C3. How you can change your care coordinator

---

## D. Care from providers

### D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care. *[Insert if applicable: Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group.]*

#### Definition of a PCP and what a PCP does do for you

*[Plans describe the following in the context of their plans:*

*What a PCP is*

*If applicable, what a medical group or IPA is*

*What types of providers may act as a PCP [If a State allows specialists to act as a PCP, plans must inform members of this and under what circumstances a specialist may be a PCP.]*

*The role of a PCP in*

- *Coordinating covered services*
- *Making decisions about or getting prior authorization (PA), if applicable*

*When a clinic can be your PCP (RHC/FQHC)]*

#### Your choice of PCP



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans describe how to choose a PCP. Plans that assign members to medical groups or IPAs must include language that explains how the choice of PCP will affect member access to specialists and hospitals. For example:*

*If there is a particular specialist or hospital that you want to use, find out if they're affiliated with your PCP's medical group. You can look in the [Provider and Pharmacy Directory](#), or ask Member Services to find out if the PCP you want makes referrals to that specialist or uses that hospital.]*

### Option to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

*[Plans describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.).]*

*[Insert if applicable: Our plan's PCPs are affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for a change, tell Member Services if you use a specialist or get other covered services that must have PCP approval. Member Services helps you continue your specialty care and other services when you change your PCP.]*

### Services you can get without approval from your PCP

*[Note: Insert this section only if plans require referrals to network providers.]*

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to a network provider (for example, if you're outside our plan's service area or during the weekend).

**Note:** Urgently needed care must be immediately needed and medically necessary.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccinations *[insert if applicable: as well as hepatitis B vaccinations and pneumonia vaccinations]* *[insert if applicable: as long as you get them from a network provider]*.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams *[insert if applicable: as long as you get them from a network provider]*.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.

*[Plans add additional bullets consistently formatted like the rest of this section as appropriate.]*

## D2. Care from specialists and other network providers

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

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

*[Plans describe how members access specialists and other network providers, including:*

*The role (if any) of the PCP in referring members to specialists and other providers.*

*A description of PA as well as the process for getting PA [Plans explain that PA means the member gets plan approval before getting a specific service or drug or using an out-of-network provider, and plans include information about who makes the PA decision (e.g., Medical Director, the PCP, or another entity).] Refer members to Chapter 4 for information about which services require PA.*

*If PCP selection results in being limited to specific specialists or hospitals to which that PCP refers [For example, plans include information about subnetworks.]]*

*[Plans with referral models, insert: A written referral may be for one visit or it may be a standing referral for more than one visit if you need ongoing services. We must give you a standing referral to a qualified specialist for any of these conditions:*

- A chronic (ongoing) condition;



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- A life-threatening mental or physical illness;
- A degenerative disease or disability;
- Any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a written referral when needed, the bill may not be paid. For more information, call Member Services at the number at the bottom of this page.]

*[Plans with direct access models, insert: If we are unable to find you a qualified plan network provider, we must give you a standing service authorization for a qualified specialist for any of these conditions:*

- A chronic (ongoing) condition;
- A life-threatening mental or physical illness;
- A degenerative disease or disability;
- Any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a service authorization from us when needed, the bill may not be paid. For more information, call Member Services at the phone number printed at the bottom of this page.]

### D3. When a provider leaves our plan

*[Plans may edit this section if Medicaid requires them to have a transition benefit when a provider leaves the plan.]*

A network provider you use may leave our plan. If one of your providers leaves our plan, you have certain rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we work with you to ensure, that the medically necessary treatment you are getting is not interrupted.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to Chapter 9 *[plans may insert reference, as applicable]* for more information.)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. *[Plans include contact information for assistance.]*

#### D4. Out-of-network providers

*[Plans tell members under what circumstances they can get services from out-of-network providers (e.g., when providers of specialized services are not available in network). Include Medicaid out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it.] [Note: members are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover dialysis services for ESRD members who have traveled outside the plans service area or when the provider is temporarily unavailable or not accessible and are not able to access contracted ESRD providers.]*

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or *[Insert name of state-specific Medicaid program]*.

- We cannot pay a provider who is not eligible to participate in Medicare and/or *[Insert name of state-specific Medicaid program]*.
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

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#### E. Long-term services and supports (LTSS)

*[Plans should provide applicable information about getting LTSS.]*

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#### F. Behavioral health (mental health and substance use disorder) services

*[Plans should provide applicable information about getting behavioral health services.]*

---

#### G. *[If applicable plans should add: How to get self-directed care]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans should provide applicable information about getting self-directed care, including the following subsections.]*

**G1. What self-directed care is**

**G2. Who can get self-directed care (for example, if it is limited to waiver populations)**

**G3. How to get help in employing personal care providers (if applicable)**

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**H. Transportation services**

*[Plans should provide applicable information about getting transportation services.]*

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**I. Covered services in a medical emergency, when urgently needed, or during a disaster**

**I1. Care in a medical emergency**

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- Serious risk to your health *[insert as applicable: or to that of your unborn child];*  
**or**
- Serious harm to bodily functions; **or**
- Serious dysfunction of any bodily organ or part; **or**
- *[Insert as applicable: In the case of a pregnant woman in active labor, when:*
  - there is not enough time to safely transfer you to another hospital before delivery.
  - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



territories *[insert as applicable: or worldwide]*, from any provider with an appropriate state license.

- *[Plans add if applicable: As soon as possible, tell our plan about your emergency. We follow up on your emergency care. You or someone else [plans may replace "someone else" with "your care coordinator" or other applicable term] should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us.] [Plans must provide the contact phone number and days and hours of operation or explain where to find the information (e.g., on the back of the Member ID Card).]*

### Covered services in a medical emergency

*[Plans that cover emergency medical care outside the United States or its territories through Medicaid may describe this coverage based on the Medicaid program coverage area. Plans must also include language emphasizing that Medicare does not provide coverage for emergency medical care outside the United States and its territories.]*

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

*[Plans may add to this paragraph as needed to include other information about their post-stabilization care.]* Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

### Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

After the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## 12. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need treatment.

### Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it is not possible or reasonable to get to a network provider, we cover urgently needed care you get from an out-of-network provider.

*[Plans must insert instructions for how to access urgently needed services (e.g., using urgent care centers, a provider hotline, etc.).]*

### Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider.

*[Plans that cover urgently needed care outside the United States or its territories through Medicaid may describe this coverage based on the Medicaid program coverage area.]*

Our plan does not cover urgently needed care or any other *[insert if plan covers emergency care outside of the United States and its territories: non-emergency]* care that you get outside the United States.

*[Insert if applicable: Plans with world-wide emergency/urgent coverage as a supplemental benefit: Our plan covers worldwide [insert as applicable: emergency and urgently needed care OR emergency OR urgently needed care] services outside the United States under the following circumstances [insert details.]]*

## 13. Care during a disaster

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

Visit our website for information on how to get care you need during a declared disaster: <web address>. *[In accordance with 42 CFR 422.100(m), plans must include on their web page, at a minimum, information about coverage of benefits at non-contracted facilities at network cost sharing without required PA; terms and conditions of payment for non-contracted providers; and each declared disaster's start and end dates.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at *[insert as applicable: the in-network cost-sharing rate or no cost to you]*. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of your *Member Handbook* for more information.

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## J. What to do if you are billed directly for services our plan covers

*[Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]*

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay *[plans with cost sharing, insert: our share of]* the bill.

**You should not pay the bill yourself. If you do, we may not be able to pay you back.**

*[Insert as applicable: If you paid for your covered services or If you paid more than your plan cost-sharing for covered services]* or if you got a bill for *[plans with cost sharing, insert: the full cost of]* covered medical services, refer to **Chapter 7** of your *Member Handbook* to find out what to do.

### J1. What to do if our plan does not cover services

*[Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]*

Our plan covers all services:

- That are determined medically necessary, **and**
- That are listed in our plan's Benefits Chart (refer to **Chapter 4** of your *Member Handbook*), **and**
- That you get by following plan rules.

If you get services that our plan does not cover, **you pay the full cost yourself.**

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

**Chapter 9** of your *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We pay for some services up to a certain limit. If you use over the limit, you pay the full cost to get more of that type of service. Refer to Chapter 4 for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

---

## K. Coverage of health care services in a clinical research study

### K1. Definition of a clinical research study

*[If applicable, plans revise this section to describe Medicaid role in providing coverage and payment for clinical research studies.]*

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare *[plans that conduct or cover clinical trials that are not approved by Medicare, insert: or our plan]* approves a study you want to be in, and you express interest, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

While you're in the study, you may stay enrolled in our plan. That way, our plan continues to cover you for services and care not related to the study.

If you want to take part in any Medicare-approved clinical research study, you do **not** need to tell us or get approval from us *[plans that do not use PCPs may delete the rest of this sentence]* or your primary care provider. Providers that give you care as part of the study do **not** need to be network providers.

#### **We encourage you to tell us before you take part in a clinical research study.**

If you plan to be in a clinical research study, you or your care coordinator should contact Member Services to let us know you will take part in a clinical trial.

### K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- 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 that is part of the research study.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Treatment of any side effects and complications of the new care.

*[Plans that conduct or cover clinical trials that are not approved by Medicare insert: If you volunteer for a clinical research study, we pay any costs that Medicare does not approve but that our plan approves.]* If you're part of a study that Medicare *[plans that conduct or cover clinical trials that are not approved by Medicare, insert: or our plan]* has **not** approved, you pay any costs for being in the study.

### K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website ([www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf](http://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf)). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

---

## L. How your health care services are covered in a religious non-medical health care institution

### L1. Definition of a religious non-medical health care institution

*[If applicable, plans revise this section to describe Medicaid's role in providing care in religious non-medical health care institutions.]*

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

### L2. Care from a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you get services from this institution that are provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - *[Omit this bullet if not applicable]* You must get approval from us before you are admitted to the facility, or your stay will **not** be covered.

*[Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Benefits Chart in Chapter 4 *[insert reference, as applicable]*) or whether there is unlimited coverage for this benefit.]*

---

## M. Durable medical equipment (DME)

### M1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. As a member of our plan, you *[insert if the plan sometimes allows transfer of ownership to the member: usually]* will **not** own DME, no matter how long you rent it.

*[If the plan allows transfer of ownership of certain DME items to members, the plan must modify this section to explain the conditions and when the member can own specified DME.]*

*[If the plan sometimes allows transfer of ownership to the member for DME items other than prosthetics, insert: In certain limited situations, we transfer ownership of the DME item to you. Call Member Services to find out about requirements you must meet and papers you need to provide.]*

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you will **not** own the equipment.

*[Plans should modify this section as necessary to explain any additional Medicaid coverage of DME.]*

### M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Note:** You can find definitions of Original Medicare and MA Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2023* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov/medicare-and-you](http://www.medicare.gov/medicare-and-you)) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments do not count toward the payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan

### **M3. Oxygen equipment benefits as a member of our plan**

If you qualify for oxygen equipment covered by Medicare and you're a member of our plan, we cover:

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

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

### **M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan**

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- Oxygen equipment, supplies, and services for another 24 months.
- Oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.





Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.

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<Plan name> MEMBER HANDBOOK

## Chapter 4: Benefits chart

### Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services *[insert if the plan has cost sharing: and how much you pay for each service]*. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction *[insert reference, as applicable]* appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

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**If you have questions**, please call <plan name> at <toll-free phone and TTY/TDD numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 1

H. Benefits not covered by our plan, Medicare, or *[insert name of state-specific Medicaid program]*.....50

## A. Your covered services *[insert if the plan has cost sharing: and your out-of-pocket costs]*

This chapter tells you about services our plan covers *[insert if the plan has cost-sharing: and how much you pay for each service]*. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your *Member Handbook*. *[Insert if applicable: This chapter also explains limits on some services.]*

*[Plans with cost sharing, insert: For some services, are charged an out-of-pocket cost called a copay. This is a fixed amount (for example, \$5) you pay each time you get that service. You pay the copay at the time you get the medical service.]*

*[Plans with **no** cost-sharing for any services described in this chapter, insert: Because you get assistance from *[Insert name of state-specific Medicaid program]*, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of your *Member Handbook* for details about the plan's rules.]*

If you need help understanding what services are covered, call *[insert: your care coordinator and/or Member Services at <phone number(s)>]*.

*[As applicable, plans insert the subsection heading and information below.]*

### A1. During public health emergencies

*[Plans providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describe the coverage and flexibilities here or include general information about the coverage and flexibilities along with any cross references, as applicable. Plans include whether such coverage and flexibilities are contingent upon the duration of the public health emergency, which may or may not last for the entire year. Plans also include any specific contact information, as applicable, where members can get more details.]*

**Commented [BW1]:** It looks like coinsurance language (a % of costs rather than fixed copays) was removed. This does not affect our state at the moment, but we wonder whether it should be added back for program flexibility in other states. It is still mentioned in Chapter 8.

## B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

**You should never get a bill from a provider for covered services.** If you do, refer to **Chapter 7** of your *Member Handbook* or call Member Services.

## C. About our plan's Benefits Chart



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans may add references to long-term care or home and community-based services.]*

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them. *[Plans that include an index at the end of the chapter should insert: To find a service in the chart, you can also use the index at the end of the chapter.]*

**We pay for the services listed in the Benefits Chart when the following rules are met.**

*[Plans that do not have cost-sharing, insert: You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.]*

- We provide covered Medicare and *[Insert name of state-specific Medicaid program]* covered services according to the rules set by Medicare and *[Insert name of state-specific Medicaid program]*.
- The services *[Plans may revise as applicable: (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs)]* must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise and use the state-specific definition of “medically necessary” and ensure that it is updated and used consistently in Chapter 12 and throughout member materials.]*
- *[Insert if applicable: You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your *Member Handbook* has more information about using network and out-of-network providers.]*
- *[Insert if applicable: You have a primary care provider (PCP) or a care team that is providing and managing your care. [Plans that do not require referrals, omit the rest of this paragraph:]* In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan’s network. This is called a referral. **Chapter 3** of your *Member Handbook* has more information about getting a referral and when you do **not** need one.]
- *[Insert if applicable: We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need prior authorization (PA) [insert as appropriate: with an asterisk (\*) or with a*

**Commented [BW2]:** Between this bullet and the next, our 2023 models include details about a continuity of care period and using existing providers. There was a brief instruction about it in Chapter 1, but we believe it needs further elaboration here, for states that have it. This is very important to our program at present and is likely to be carried forward into any successors. It will be important for members to be able to keep going to their existing providers for the first X days (presently 180) that they enroll in this program, and we need a space for plans to describe that.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

footnote **or** in bold type *or* in italic type].] *[Insert if applicable: In addition, you must get prior authorization (PA) for the following services not listed in the Benefits Chart: [insert list].]*

- *[Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI)” in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Members with Certain Chronic Conditions**. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [insert if applicable: and/or reduced cost sharing]:*
  - *[List all applicable chronic conditions here.]*
  - *[If offering SSBCI, include information about the process and/or criteria for determining eligibility for SSBCI. Plan must also deliver a written summary of the SSBCI offered to each chronically ill member eligible for SSBCI.]*

Refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.]

- *[Insert as applicable: Most **or** All]* preventive services are free. You find this apple  next to preventive services in the Benefits Chart.
- *[Insert any additional applicable Medicaid program coverage here such as community supports]*

*[Instructions on completing the Benefits Chart:*

- *For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.*
- *Optional supplemental benefits are not permitted in this chart; optional supplemental benefits should be described in section E.*
- *Include the following where appropriate: Talk to your provider and get a referral.*
- *Plans must include any services provided in excess of the Medicare and Medicaid requirements and identify preventive services with the apple icon.*
- *HMO POS plan types must provide information about which services must be obtained from network providers, which services can be obtained out-of-network under the POS benefit, and any differences in cost sharing for covered services obtained out-of-network under the POS benefit.*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Plans should clearly indicate which benefits are subject to prior authorization (PA). (This can be done with asterisks, footnotes, bold type, or italic type. Plans must select only one method of indication, describe it in terms easily understandable by members, make the indication and description prominently visible, and use it consistently throughout the document.)
- Plans may insert any additional benefit information that is based on the plan's approved benefit package and not already included in the Benefits Chart or in the exclusions section. Plans insert any additional benefits in the chart alphabetically.
- Plans must add any Medicaid benefits covered to the chart as instructed by the state. Insert any additional benefits in the chart alphabetically. If directed by the state, include all non-waiver services in the chart and all HCBS waiver services as a separate section after the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed. The remainder of the sections should then be renumbered.
- Plans must describe any restrictive policies, limitations, or monetary limits that might affect a member's access to services within the chart.
- Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.
- Plans should include all non-waiver LTSS in the chart in alphabetical order.
- Plans with no cost sharing for any type of service (i.e., no cost sharing at all) may delete the "what you must pay" column from the table. Plans with any type of cost sharing for services, including for pharmacy services, must leave the "what you must pay" column in the table.
- Plans offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:
  - Deliver to each clinically-targeted member a written summary of those benefits so that such member are notified of the "Uniformity Flexibility" benefits for which they are eligible.
  - Update the Benefits Chart to include details, as applicable, about the exact targeted reduced cost sharing amount for each specific service and/or the additional supplemental benefits being offered.]

**Commented [BW3]:** This – and many other changes – are likely to be extensive. If states do not have the opportunity to modify these models before sharing them with our plans, how does CMS expect us to instruct or communicate these changes to plans and ensure consistency and accuracy in the handbooks?

**Commented [BW4]:** Typo

**Commented [BW5]:** We anticipate directing plans to do this, assuming HCBS services continue to be included in 2024. We believe it was clearer to keep this as its own bullet, but we thank CMS for including it here.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

D. Our plan’s Benefits Chart

*[When a benefit continues from one page to the next, plans enter a blank return before right aligning and inserting at the bottom of the first part of the description: **This benefit is continued on the next page.** At the top of the next page where the benefit description continues, plans enter the benefit name again in bold followed by (continued). Plans may refer to **Durable medical equipment (DME) and related supplies** and other benefits later in this chart as examples. Plans should also be aware that the flow of benefits from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed.]*

*[Plans should modify this section throughout to reflect Medicaid or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medicaid.]*

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay                                               |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
|  | <p><b>Abdominal aortic aneurysm screening</b></p> <p>We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <p><b>Acupuncture</b></p> <p>We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as:</p> <ul style="list-style-type: none"> <li>• lasting 12 weeks or longer;</li> <li>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);</li> <li>• not associated with surgery; <b>and</b></li> <li>• <b>not associated with pregnancy.</b></li> </ul> <p>In addition, we pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.</p> <p>Acupuncture treatments must be stopped if you don't get better or if you get worse.</p> <p><a href="#">[List any additional benefits offered.]</a></p> | <p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p> |
| <p> <b>Alcohol misuse screening and counseling</b></p> <p>We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.</p> <p>If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.</p> <p><a href="#">[List any additional benefits offered.]</a></p>                                                                                                                                                                                                                                              | <p>\$0</p>                                                               |

**Commented [BW6]:** Our state is considering how pregnancy and pregnant members might interact with this program, and we believe that the care coordination services offered in this program would be beneficial. However, pregnancy-related services are barely mentioned in this model, perhaps because they are not thought of as a typical Medicare service. Prenatal care, delivery/childbirth, and post-natal care are just a few examples of the kind of detail we might need to add to this table in order to accurately describe "any Medicaid benefits" as directed above. We are flagging this so CMS can consider whether instructions in this draft are sufficient and flexible enough.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | What you must pay                                                 |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
|    | <b>Ambulance services</b><br><br>Covered ambulance services include ground, air (airplane and helicopter), and rotary-wing ambulance services. The ambulance will take you to the nearest place that can give you care.<br><br>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases must be approved by us.<br><br>In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. | \$0                                                               |
|  | <b>Annual wellness visit</b><br><br>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                                                                                                                                                                                                                                                  | \$0                                                               |
|  | <b>Bone mass measurement</b><br><br>We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.<br><br>We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                            | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
|  <p><b>Breast cancer screening (mammograms)</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>One baseline mammogram between the ages of 35 and 39 <i>[plans that only cover ages 65 and older should delete]</i></li> <li>One screening mammogram every 12 months <i>[plans that cover women under 65 should include: for women age 40 and older]</i></li> <li>Clinical breast exams once every 24 months</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                    | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><b>Cardiac (heart) rehabilitation services</b></p> <p>We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's <i>[insert as appropriate: referral or order]</i>.</p> <p>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.</p>                                                                                                                                                                                                                                              | <p>\$0</p>                                                      |
|  <p><b>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</b></p> <p>We pay for one visit a year, or more if medically necessary, with your primary care provider to help lower your risk for heart disease. During the <i>[insert: visit or visits]</i>, your doctor may:</p> <ul style="list-style-type: none"> <li>Discuss aspirin use,</li> <li>Check your blood pressure, <b>and/or</b></li> <li>Give you tips to make sure you are eating well.</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                                        |
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|  <b>Cardiovascular (heart) disease testing</b><br>We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                         | \$0<br><i>[List copays for additional benefits.]</i>                     |
|  <b>Cervical and vaginal cancer screening</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>For all women: Pap tests and pelvic exams once every 24 months</li> <li>For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months</li> <li><i>[Plans that cover women under 65 must include: For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months]</i></li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><i>[List copays for additional benefits.]</i>                     |
| <b>Chiropractic services</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>Adjustments of the spine to correct alignment</li> </ul> <i>[List any Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.]</i>                                                                                                                                                                                                                                                                                                                         | <i>[List copays.]</i><br><i>[List copays for supplemental benefits.]</i> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                                               |
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|  <b>Colorectal cancer screening</b><br>For people 50 and older, we pay for the following services: <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema) every 48 months</li> <li>• Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months</li> <li>• DNA based colorectal screening, every 3 years</li> <li>• Screening Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy)</li> <li>• Screening Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months.</li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><br><i>[List copays for additional benefits.]</i>                        |
| <i>[Include row if applicable and modify to accurately describe the Medicaid and/or supplemental benefit offered.]</i><br><b>Dental services</b><br>Certain dental services, including cleanings, fillings, and dentures, are available through the <i>[insert name of Medicaid program or integrated name]</i> Dental Program.<br><i>[Plans that offer optional supplemental dental benefits insert: Note: Our plan offers additional dental services. Got to Benefits Chart in Section E for more information.]</i>                                                                                                                                                                                                                                 | <i>[If plan offers supplemental benefit, the maximum copay amount is \$10.]</i> |
|  <b>Depression screening</b><br>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                                                                                                                                                                             | \$0<br><br><i>[List copays for additional benefits.]</i>                        |

**Commented [BW7]:** We appreciate this. The interaction of this program with dental benefits in our state requires more explanation.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay                                                 |
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|  <b>Diabetes screening</b><br><br>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: <ul style="list-style-type: none"><li>• High blood pressure (hypertension)</li><li>• History of abnormal cholesterol and triglyceride levels (dyslipidemia)</li><li>• Obesity</li><li>• History of high blood sugar (glucose)</li></ul> Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.<br><br>Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.<br><br><a href="#">[List any additional benefits offered.]</a> | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | What you must pay                                                                                                                         |
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| <div data-bbox="154 464 191 506"></div> <div data-bbox="212 470 824 499"><b>Diabetic self-management training, services, and supplies</b></div> <div data-bbox="212 520 773 575"><p>We pay for the following services for all people who have diabetes (whether they use insulin or not):</p></div> <div data-bbox="212 588 797 1218"><ul style="list-style-type: none"><li>• Supplies to monitor your blood glucose, including the following:<ul style="list-style-type: none"><li>○ A blood glucose monitor</li><li>○ Blood glucose test strips</li><li>○ Lancet devices and lancets</li><li>○ Glucose-control solutions for checking the accuracy of test strips and monitors</li></ul></li><li>• For people with diabetes who have severe diabetic foot disease, we pay for the following:<ul style="list-style-type: none"><li>○ One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, <b>or</b></li><li>○ One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)</li></ul></li><li>• In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.</li></ul></div> <div data-bbox="212 1232 568 1260"><a href="#">[List any additional benefits offered.]</a></div> | <div data-bbox="883 470 911 497">\$0</div> <div data-bbox="883 512 1073 567"><a href="#">[List copays for additional benefits.]</a></div> |



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| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| <p><b>Durable medical equipment (DME) and related supplies</b></p> <p>Refer to Chapter 12 of your <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).”</p> <p>We cover the following items:</p> <ul style="list-style-type: none"> <li>• Wheelchairs</li> <li>• Crutches</li> <li>• Powered mattress systems</li> <li>• Diabetic supplies</li> <li>• Hospital beds ordered by a provider for use in the home</li> <li>• Intravenous (IV) infusion pumps and pole</li> <li>• Speech generating devices</li> <li>• Oxygen equipment and supplies</li> <li>• Nebulizers</li> <li>• Walkers</li> <li>• Standard curved handle or quad cane and replacement supplies</li> <li>• Cervical traction (over the door)</li> <li>• Bone stimulator</li> <li>• Dialysis care equipment</li> </ul> <p>Other items may be covered.</p> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays, including how they vary for equipment covered by Medicare and Medicaid, if applicable.]</i></p> <p><i>[Include if applicable: Your cost sharing for Medicare oxygen equipment coverage is [insert copay amount or coinsurance percentage], every [insert required frequency of payment].]</i></p> <p><i>[Plans that use a constant cost-sharing structure for oxygen equipment insert: Your cost sharing will not change after being enrolled for 36 months.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay                                                                                                                                                                                                                                                                                                                                                                              |
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| <p><b>Durable medical equipment (DME) and related supplies (continued)</b></p> <p><i>[Plans that do not limit the DME brands and manufacturers that they cover, insert: We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.]</i></p> <p><i>[Plans that limit the DME brands and manufacturers that they cover, insert the following (for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual): With this Member Handbook, we sent you our plan's list of DME. The list tells you the brands and makers of DME that we pay for. You may also find the most recent list of brands, makers, and suppliers on our website at &lt;URL&gt;.</i></p> <p>Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We do not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to our plan and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)</p> <p>If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor may file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is right for your medical condition. For more information about appeals, refer to <b>Chapter 9</b> of your <i>Member Handbook</i>.]</p> | <p><i>[Plans that wish to vary cost sharing for oxygen equipment after 36 months insert details including whether original cost sharing resumes after 5 years and you are still in the plan.] [If cost sharing is different for members who made 36 months of rental payments prior to joining the plan insert: If prior to enrolling in [insert plan name] is [insert cost sharing].]</i></p> |



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| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                                 |
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| <p><b>Emergency care</b></p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> <li>Given by a provider trained to give emergency services, <b>and</b></li> <li>Needed to treat a medical emergency.</li> </ul> <p>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> <li>Serious risk to your health <i>[Plans that cover women under 65 must include: or to that of your unborn child]; or</i></li> <li>Serious harm to bodily functions; <b>or</b></li> <li>Serious dysfunction of any bodily organ or part; <b>or</b></li> <li><i>[Plans that cover women under 65 must include: In the case of a pregnant woman in active labor, when:</i> <ul style="list-style-type: none"> <li>There is not enough time to safely transfer you to another hospital before delivery.</li> <li>A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]</li> </ul> </li> </ul> <p><i>[Also identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.]</i></p> | <p><b>\$0</b></p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, <i>[plans should insert information as needed to accurately describe emergency care benefits: (e.g., you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.)]</i>.</p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay            |
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| <p><i>[If family planning services are covered, plans should modify this as necessary.]</i></p> <p><b>Family planning services</b></p> <p>The law lets you choose any provider for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Family planning exam and medical treatment</li> <li>• Family planning lab and diagnostic tests</li> <li>• Family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring)</li> <li>• Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)</li> <li>• Counseling and diagnosis of infertility and related services</li> <li>• Counseling, testing, and treatment for sexually transmitted infections (STIs)</li> <li>• Counseling and testing for HIV and AIDS, and other HIV-related conditions</li> <li>• Permanent Contraception (You must be age 21 or older to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.)</li> <li>• Genetic counseling</li> </ul> <p>We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:</p> <ul style="list-style-type: none"> <li>• Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)</li> <li>• Treatment for AIDS and other HIV-related conditions</li> <li>• Genetic testing</li> </ul> | <p><i>[List copays.]</i></p> |



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| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                                      |
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|  <b>Health and wellness education programs</b><br><i>[These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness and stress management. Describe the nature of the programs here.]</i><br><i>[If this benefit is not applicable, plans should delete this row.]</i>                                                                                                                                                                                                             | <i>[List copays.]</i>                                                  |
| <i>[Plans should modify this section to reflect plan-covered benefits as appropriate.]</i><br><b>Hearing services</b><br>We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.                                                                                                                                                                                                                                                                                                                                                                | <i>[List copays.]</i><br><i>[List copays for additional benefits.]</i> |
| <i>[If this benefit is not applicable, plans should delete this row.]</i><br><b>Help with certain chronic conditions</b><br><i>[Plans that offer targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI),” which members with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits and (as applicable) reduced cost sharing. If offering SSBCI, plans must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package submission.]</i> | <i>[List copays.]</i>                                                  |



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| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay                                               |
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|  <p><b>HIV screening</b></p> <p>We pay for one HIV screening exam every 12 months for people who:</p> <ul style="list-style-type: none"> <li>• Ask for an HIV screening test, <b>or</b></li> <li>• Are at increased risk for HIV infection.</li> </ul> <p>For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><b>Home health agency care</b></p> <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p>Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• 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.)</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> </ul> | <p><i>[List copays.]</i></p>                                    |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                                                                   |
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| <p><b>Home infusion therapy</b></p> <p>Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:</p> <ul style="list-style-type: none"><li>• The drug or biological substance, such as an antiviral or immune globulin;</li><li>• Equipment, such as a pump; <b>and</b></li><li>• Supplies, such as tubing or a catheter.</li></ul> <p>Our plan covers home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"><li>• Professional services, including nursing services, provided in accordance with your care plan;</li><li>• Member training and education not already included in the DME benefit;</li><li>• Remote monitoring; <b>and</b></li><li>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.</li></ul> <p><a href="#">[List any additional benefits offered.]</a></p> | <p><a href="#">[List copays.]</a></p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                                                                                    |
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| <p><b>Hospice care</b></p> <p>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Our plan pays for the following while you get hospice services:</p> <ul style="list-style-type: none"> <li>• Drugs to treat symptoms and pain</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul> <p><b>Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.</b></p> <ul style="list-style-type: none"> <li>• Refer to <b>Section F</b> of this chapter for more information.</li> </ul> <p><b>For services covered by our plan but not covered by Medicare Part A or Medicare Part B:</b></p> <ul style="list-style-type: none"> <li>• Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay <i>[insert as appropriate: our plan's cost-sharing amount or nothing]</i> for these services.</li> </ul> <p><b>For drugs that may be covered by our plan's Medicare Part D benefit:</b></p> <ul style="list-style-type: none"> <li>• Drugs are never covered by both hospice and our plan at the same time. For more information, refer to <b>Chapter 5</b> of your <i>Member Handbook</i>.</li> </ul> <p><b>Note:</b> If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that is <b>not</b> related to your terminal prognosis.</p> <p><i>[Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.]</i></p> | <p><i>[List copays.]</i></p> <p><i>[Include information about cost sharing for hospice consultation services if applicable.]</i></p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay                                                        |
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| <div data-bbox="154 464 191 506"></div> <p><b>Immunizations</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine</li> <li>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary</li> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B</li> <li>• COVID-19 vaccines</li> <li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li> </ul> <p>We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to <b>Chapter 6</b> of your <i>Member Handbook</i> to learn more.</p> <p><a href="#">[List any additional benefits offered.]</a></p> | <p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                    |
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| <p><b>Inpatient hospital care</b></p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p><i>[List any restrictions that apply.]</i></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units, such as intensive care or coronary care units</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Needed surgical and medical supplies</li> <li>• Appliances, such as wheelchairs</li> <li>• Operating and recovery room services</li> <li>• Physical, occupational, and speech therapy</li> <li>• Inpatient substance abuse services</li> <li>• In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><b>\$0</b></p> <p>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.</p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay |
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| <p><b>Inpatient hospital care (continued)</b></p> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. <i>[Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.]</i></p> <ul style="list-style-type: none"> <li>• Blood, including storage and administration</li> <li>• Physician services</li> </ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are you a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> |                   |
| <p><b>Inpatient services in a psychiatric hospital</b></p> <p>We pay for mental health care services that require a hospital stay. <i>[List days covered, restrictions such as 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.]</i></p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay |
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| <p><i>[Plans with no day limitations on a plan's hospital or nursing facility coverage may modify or delete this row as appropriate.]</i></p> <p><b>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</b></p> <p>We do not pay for your inpatient stay if it is not reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Doctor services</li> <li>• Diagnostic tests, like lab tests</li> <li>• X-ray, radium, and isotope therapy, including technician materials and services</li> <li>• Surgical dressings</li> <li>• Splints, casts, and other devices used for fractures and dislocations</li> <li>• Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: <ul style="list-style-type: none"> <li>○ An internal body organ (including contiguous tissue), <b>or</b></li> <li>○ The function of an inoperative or malfunctioning internal body organ.</li> </ul> </li> <li>• Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition</li> <li>• Physical therapy, speech therapy, and occupational therapy</li> </ul> | <p>\$0</p>        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay |
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| <p><b>Kidney disease services and supplies</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services.</li><li>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in <b>Chapter 3</b> of your <i>Member Handbook</i>, or when your provider for this service is temporarily unavailable or inaccessible.</li><li>• Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care</li><li>• Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments</li><li>• Home dialysis equipment and supplies</li><li>• Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply.</li></ul> <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.</p> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay                                               |
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|  <p><b>Lung cancer screening</b></p> <p>Our plan pays for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> <li>• Are aged 50-77, <b>and</b></li> <li>• Have a counseling and shared decision-making visit with your doctor or other qualified provider, <b>and</b></li> <li>• Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.</li> </ul> <p>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.</p> <p><i>[Modify section to accurately describe benefits and list any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                           | <p>\$0</p>                                                      |
|  <p><b>Medical nutrition therapy</b></p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when <i>[insert as appropriate: referred or ordered]</i> by your doctor.</p> <p>We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.</p> <p>We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's <i>[insert as appropriate: referral or order]</i>. A doctor must prescribe these services and renew the <i>[insert as appropriate: referral or order]</i> each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
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|  <p><b>Medicare Diabetes Prevention Program (MDPP)</b></p> <p>Our plans pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none"> <li>• Long-term dietary change, <b>and</b></li> <li>• Increased physical activity, <b>and</b></li> <li>• Ways to maintain weight loss and a healthy lifestyle.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$0               |
| <p><b>Medicare Part B prescription drugs</b></p> <p><i>[Plans that do or expect to use Medicare Part B step therapy should indicate the Medicare Part B drug categories below that are or may be subject to Medicare Part B step therapy as well as a link to a list of drugs subject to Medicare Part B step therapy. Plans may update the link throughout the year and add any changes at least 30 days prior to implementation per 42 CFR 422.111(d).]</i></p> <p>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs:</p> <ul style="list-style-type: none"> <li>• Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <li>• Osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> </ul> <p><b>This benefit is continued on the next page</b></p> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay |
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| <p><b>Medicare Part B prescription drugs (continued)</b></p> <ul style="list-style-type: none"> <li>Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents <i>[plans may delete any of the following drugs that they do not not cover]</i> (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</li> <li>IV immune globulin for the home treatment of primary immune deficiency diseases</li> </ul> <p><i>[Insert if applicable: The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: &lt;hyperlink&gt;.]</i></p> <p>We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit.</p> <p><b>Chapter 5</b> of your <i>Member Handbook</i> explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p><b>Chapter 6</b> of your <i>Member Handbook</i> explains what you pay for your outpatient prescription drugs through our plan.</p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay            |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate or eliminate this section if not covered.]</i></p> <p><b>Nursing facility care</b></p> <p>A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital.</p> <p>Services that we pay for include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Nursing services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Respiratory therapy</li> <li>• Drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)</li> <li>• Blood, including storage and administration</li> <li>• Medical and surgical supplies usually given by nursing facilities</li> <li>• Lab tests usually given by nursing facilities</li> <li>• X-rays and other radiology services usually given by nursing facilities</li> <li>• Use of appliances, such as wheelchairs usually given by nursing facilities</li> <li>• Physician/practitioner services</li> <li>• Durable medical equipment</li> <li>• Dental services, including dentures</li> <li>• Vision benefits</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays.]</i></p> |

**Commented [BW10]:** In our state, it is difficult to calculate copays because they depend on income. We would prefer to be able to refer members to their care coordinator or some other resource for help, or at least specify some standard language for our plans to use. Something like, "Please contact us at the number at the bottom of the page to learn if you will need to contribute toward your nursing home care."

**Commented [BW8]:** As allowed in Chapter 1, our state is likely to modify this to read, "Nursing home care," potentially without using the NF acronym.

**Commented [BW9]:** It does not look like this acronym is used again, so should it be removed?



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                               |
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| <p><b>Nursing facility care (continued)</b></p> <ul style="list-style-type: none"> <li>• Hearing exams</li> <li>• Chiropractic care</li> <li>• Podiatry services</li> </ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> <li>• A nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care).</li> <li>• A nursing facility where your spouse or domestic partner is living at the time you leave the hospital.</li> </ul> |                                                                 |
| <p> <b>Obesity screening and therapy to keep weight down</b></p> <p>If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                         | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay |
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| <p><b>Opioid treatment program (OTP) services</b></p> <p>Our plan pays for the following services to treat opioid use disorder (OUD):</p> <ul style="list-style-type: none"><li>• Intake activities</li><li>• Periodic assessments</li><li>• Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications</li><li>• Substance use counseling</li><li>• Individual and group therapy</li><li>• Testing for drugs or chemicals in your body (toxicology testing)</li></ul> <p><i>[List any other medically necessary treatment or additional benefits offered, with the exception of meals and transportation.]</i></p> | \$0               |
| <p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"><li>• X-rays</li><li>• Radiation (radium and isotope) therapy, including technician materials and supplies</li><li>• Surgical supplies, such as dressings</li><li>• Splints, casts, and other devices used for fractures and dislocations</li><li>• Lab tests</li><li>• Blood, including storage and administration</li><li>• Other outpatient diagnostic tests</li></ul> <p><i>[Plans can include other covered tests as appropriate.]</i></p>                    | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay                                               |
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| <p><b>Outpatient hospital services</b></p> <p>We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services <ul style="list-style-type: none"> <li>○ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.”</li> <li>○ Sometimes you can be in the hospital overnight and still be “outpatient.”</li> <li>○ You can get more information about being inpatient or outpatient in this fact sheet: <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a></li> </ul> </li> <li>• Labs and diagnostic tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies, such as splints and casts</li> <li>• Preventive screenings and services listed throughout the Benefits Chart</li> <li>• Some drugs that you can’t give yourself</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay                                               |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient mental health care</b></p> <p>We pay for mental health services provided by:</p> <ul style="list-style-type: none"><li>• A state-licensed psychiatrist or doctor</li><li>• A clinical psychologist</li><li>• A clinical social worker</li><li>• A clinical nurse specialist</li><li>• A nurse practitioner</li><li>• A physician assistant</li><li>• Any other Medicare-qualified mental health care professional as allowed under applicable state laws</li></ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient rehabilitation services</b></p> <p>We pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p>                                                                                                                                                                                               | <p>\$0</p>                                                      |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay            |
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| <p><b>Outpatient substance abuse services</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Alcohol misuse screening and counseling</li> <li>• Treatment of drug abuse</li> <li>• Group or individual counseling by a qualified clinician</li> <li>• Subacute detoxification in a residential addiction program</li> <li>• Alcohol and/or drug services in an intensive outpatient treatment center</li> <li>• Extended-release Naltrexone (vivitrol) treatment</li> </ul> <p><i>[Modify this list accurately describe benefits offered or add any additional benefits offered.]</i></p>                                                                                        | <p><i>[List copays.]</i></p> |
| <p><b>Outpatient surgery</b></p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p>                   |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Partial hospitalization services</b></p> <p>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.</p> <p><i>[Network plans that do not have an in-network community mental health center may add: <b>Note:</b> Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.]</i></p> | <p>\$0</p>                   |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | What you must pay                                               |
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| <p><b>Physician/provider services, including doctor's office visits</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Medically necessary health care or surgery services given in places such as:</li><li>• Physician's office</li><li>• Certified ambulatory surgical center</li><li>• Hospital outpatient department</li><li>• Consultation, diagnosis, and treatment by a specialist</li><li>• Basic hearing and balance exams given by your <i>[insert as applicable: primary care provider or specialist]</i>, if your doctor orders them to find out whether you need treatment</li><li>• <i>[Insert if providing any additional telehealth benefits consistent with 42 CFR § 422.135 in the plan's approved Plan Benefit Package submission: Certain telehealth services, including [insert general description of covered additional telehealth benefits (i.e., the specific Medicare Part B service(s) the plan has identified as clinically appropriate for offering through electronic exchange when the provider is not in the same location as the member). Plans may refer members to their medical coverage policy here].]</i></li></ul> <p><b>This benefit is continued on the next page</b></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"><li>○ 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. <i>[Plans may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.]</i></li><li>○ <i>[List the available means of electronic exchange used for each Medicare Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.]</i></li><li>● <i>[Insert if the plan's service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act: Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare]</i></li><li>● Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home</li><li>● Telehealth services to diagnose, evaluate, or treat symptoms of a stroke</li><li>● Telehealth services for members with a substance use disorder or co-occurring mental health disorder</li></ul> <p><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> <li>○ You have an in-person visit within 6 months prior to your first telehealth visit</li> <li>○ You have an in-person visit every 12 months while receiving these telehealth services</li> <li>○ Exceptions can be made to the above for certain circumstances</li> </ul> </li> <li>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.</li> <li>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b> <ul style="list-style-type: none"> <li>○ you're not a new patient <b>and</b></li> <li>○ The check-in isn't related to an office visit in the past 7 days and</li> <li>○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> <li>• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours <b>if</b>: <ul style="list-style-type: none"> <li>○ you're not a new patient and</li> <li>○ The evaluation isn't related to an office visit in the past 7 days <b>and</b></li> <li>○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient</li> <li>• Second opinion <i>[insert if appropriate: by another network provider]</i> before surgery</li> <li>• Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> <li>○ Surgery of the jaw or related structures</li> <li>○ Setting fractures of the jaw or facial bones</li> <li>○ Pulling teeth before radiation treatments of neoplastic cancer</li> <li>○ Services that would be covered when provided by a physician</li> </ul> </li> </ul> <p><i>[List any additional benefits offered.]</i></p> |                                                                 |
| <p><b>Podiatry services</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)</li> <li>• Routine foot care for members with conditions affecting the legs, such as diabetes</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p> <b>Prostate cancer screening exams</b></p> <p><i>[Plans that cover men under age 65 must include: For men age 50 and older,]</i> we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> <li>• A digital rectal exam</li> <li>• A prostate specific antigen (PSA) test</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Prosthetic devices and related supplies</b></p> <p>Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> <li>• Colostomy bags and supplies related to colostomy care</li> <li>• Pacemakers</li> <li>• Braces</li> <li>• Prosthetic shoes</li> <li>• Artificial arms and legs</li> <li>• Breast prostheses (including a surgical brassiere after a mastectomy)</li> </ul> <p>We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.</p> <p><i>[Plans that pay for prosthetic dental devices, delete the following sentence:]</i> We will not pay for prosthetic dental devices.</p> | <p>\$0</p>                                                      |
| <p><b>Pulmonary rehabilitation services</b></p> <p>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have <i>[insert as appropriate: a referral or an order]</i> for pulmonary rehabilitation from the doctor or provider treating the COPD.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <div data-bbox="154 468 191 506"></div> <div data-bbox="207 468 860 531"><b>Sexually transmitted infections (STIs) screening and counseling</b></div> <div data-bbox="207 548 860 747"><p>We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered <a href="#">[plans that cover women under age 65 should include: for pregnant women and]</a> for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.</p><p>We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.</p><p><a href="#">[Also list any additional benefits offered.]</a></p></div> | <div data-bbox="876 468 1079 569">\$0<br/><a href="#">[List copays for additional benefits.]</a></div> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | What you must pay |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Skilled nursing facility (SNF) care</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"><li>• A semi-private room, or a private room if it is medically necessary</li><li>• Meals, including special diets</li><li>• Nursing services</li><li>• Physical therapy, occupational therapy, and speech therapy</li><li>• Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors</li><li>• Blood, including storage and administration</li><li>• Medical and surgical supplies given by nursing facilities</li><li>• Lab tests given by nursing facilities</li><li>• X-rays and other radiology services given by nursing facilities</li><li>• Appliances, such as wheelchairs, usually given by nursing facilities</li><li>• Physician/provider services</li></ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"><li>• A nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)</li><li>• A nursing facility where your spouse or domestic partner lives at the time you leave the hospital</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay                                                          |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
|  | <p><b>Smoking and tobacco use cessation</b></p> <p>If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit:</p> <ul style="list-style-type: none"><li>• We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.</li></ul> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</p> <ul style="list-style-type: none"><li>• We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</li></ul> <p><a href="#">[List any additional benefits offered.]</a></p> | <p>\$0</p> <p><a href="#">[List copays for supplemental benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Supervised exercise therapy (SET)</b></p> <p>We pay for SET for members with symptomatic peripheral artery disease (PAD) <i>[insert if applicable: who have a referral for PAD from the physician responsible for PAD treatment]</i>.</p> <p>Our plan pays for:</p> <ul style="list-style-type: none"><li>• Up to 36 sessions during a 12-week period if all SET requirements are met</li><li>• An additional 36 sessions over time if deemed medically necessary by a health care provider</li></ul> <p>The SET program must be:</p> <ul style="list-style-type: none"><li>• 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)</li><li>• In a hospital outpatient setting or in a physician's office</li><li>• Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD</li><li>• Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Urgently needed care</b></p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"> <li>• A non-emergency that requires immediate medical care, <b>or</b></li> <li>• A sudden medical illness, <b>or</b></li> <li>• An injury, <b>or</b></li> <li>• A condition that needs care right away.</li> </ul> <p>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or during the weekend).</p> <p><i>[Include in-network benefits. Also identify whether this coverage is within the U.S. and its territories or is supplemental world-wide emergency/urgent coverage.]</i></p> | <p>\$0</p>        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
|  <i>[Plans should modify this section to reflect Medicaid and plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]</i><br><b>Vision care</b><br><br>We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.<br><br>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: <ul style="list-style-type: none"><li>• People with a family history of glaucoma</li><li>• People with diabetes</li><li>• African-Americans <i>[plans that cover under 65 must include: who are age 50 and older]</i></li><li>• Hispanic Americans <i>[plans that cover under 65 must include: who are 65 or older]</i></li></ul> <i>[Plans should modify this description if the plan offers more than is covered by Medicare.]</i> We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.<br><br>If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery. | <i>[List copays.]</i><br><br><i>[List copays for additional benefits.]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
|  <p><b>“Welcome to Medicare” preventive visit</b></p> <p>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> <li>• A review of your health,</li> <li>• Education and counseling about the preventive services you need (including screenings and shots), <b>and</b></li> <li>• Referrals for other care if you need it.</li> </ul> <p><b>Note:</b> We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.</p> | \$0               |

## E. Extra “Optional Supplemental” benefits you can buy

*[Include this section if you offer optional supplemental benefits in the plan and describe benefits below. Plans must explain how these benefits are different than what is covered under Medicaid and must indicate if any of the optional supplemental benefits are covered by Medicaid. You may include this section either in the Member Handbook or as an insert to the Member Handbook.]*

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package. These extra benefits are called “**Optional Supplemental Benefits**.” If you want these optional supplemental benefits, you must sign up for them *[insert if applicable: and you may have to pay an additional premium for them.]* The optional supplemental benefits described in *[insert as applicable: this section OR the enclosed insert]* are subject to the same appeals process as any other benefits.

*[Insert plan specific optional supplemental benefits, premiums, deductible, copays, and coinsurance and rules using a chart like the Benefits Chart above. Insert plan specific procedures on how to elect optional supplemental coverage, including application process and effective dates and on how to discontinue optional supplemental coverage, including refund of premiums. Also, insert any restrictions on members’ re-applying for optional supplemental coverage (e.g., must wait until next annual enrollment period).]*

**Commented [BW11]:** As noted earlier, our state currently has plans offering some supplemental benefits at no cost. If possible, we would like to make sure the model is flexible to allow this in 2024 as well, potentially by modifying instructions to specifically address \$0 copays or benefits at no cost.

**Commented [BW12]:** Example of above: If members do not have to pay an additional premium, should the title of the section be “...benefits you can get” instead of “...benefits you can buy”?



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.



## F. Our plan's visitor or traveler benefits

*[If your plan offers a visitor/traveler program to members who are out of your service area, insert this section, adapting and expanding the following paragraphs as needed to describe the traveler benefits and rules related to getting the out-of-area coverage. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR §422.74(b)(4)(iii) (for more than 6 months up to 12 months), also explain that here based on the language suggested below:]*

If you are out of the plan's service area for more than 6 months at a time but do not permanently move, we usually must disenroll you from our plan. However, we offer a visitor/traveler program *[specify areas where the visitor/traveler program is being offered]* that allows you to remain enrolled in our plan when you are outside of our service area for up to 12 months. Under our visitor/traveler program, you get all plan-covered services at in-network cost-sharing prices. Contact us for help in finding a provider when you use the visitor/traveler benefit.

If you are in a visitor/traveler area, you can stay enrolled in the plan until <end date>. If you don't return to our plan's service area by <end date>, we will end your membership in our plan.]

## G. Benefits covered outside of our plan

*[Plans should modify this section to include additional benefits covered outside the plan by Medicaid fee-for-service and/or a Medicaid managed care plan, as appropriate.]*

We don't cover the following services, but they are available through Medicare or *[insert name state-specific name of Medicaid program]*.

### G1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

#### For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

#### For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis

**Commented [BW13]:** We have some Medicaid-covered services we would like to include here, such as dental and non-emergency transportation. It looks like plans "should modify" this section to include them, but, similar to an earlier comment, how can we ensure consistent descriptions across plans?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

#### For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook*.

**Note:** If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care not related to your terminal prognosis.

---

## H. Benefits not covered by our plan, Medicare, or *[insert name of state-specific Medicaid program]*.

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medicaid do not for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan does not cover the following items and services:

*[The services listed in the remaining bullets are excluded from Medicare's and Medicaid's benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Medicaid or have become covered due to a Medicare or Medicaid change in coverage policy, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans may add parenthetical references to the Benefits Chart for descriptions of covered services and items as appropriate. Plans may also add exclusions as needed.]*

- Services considered not "reasonable and medically necessary," according to Medicare and *[insert name state-specific name of Medicaid program]* standards, unless we list these as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Refer to **Chapter 3** of your *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it.
- A private room in a hospital, except when medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- *[Plans should delete this if the state allows:]* Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines.
- Routine foot care, except as described in Podiatry services in the Benefits Chart in Section D.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- *[Plans delete this if supplemental:]* Regular hearing exams, hearing aids, or exams to fit hearing aids.
- *[Plans delete this if supplemental:]* Radial keratotomy, LASIK surgery, and other low-vision aids.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. [\[Zero cost-sharing plans may adjust this language as applicable\]](#) However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.*

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## Chapter 5: Getting your outpatient prescription drugs

### Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and *[Insert name of Medicaid program]*. *[Plans with no cost sharing, delete the next sentence.]* **Chapter 6** of your *Member Handbook* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

We also cover the following drugs, although they are not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please refer to Chapter 5, Section F "If you are in a Medicare-certified hospice program."

### Rules for our plan's outpatient drug coverage

*[If coverage includes Medicaid drugs, please add language as needed for Medicaid.]* We usually cover your drugs as long as you follow the rules in this section.

You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). *[Plans may modify or delete the next sentence as appropriate.]* It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists *[insert as applicable: or any similar Medicaid lists]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

You generally must use a network pharmacy to fill your prescription.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "Drug List" for short.

- If it is not on the Drug List, we may be able to cover it by giving you an exception.
- Refer to Chapter 9 *[insert reference, as applicable]* to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration or supported by certain medical references. Your doctor may be able to help identify medical references to support the requested use of the prescribed drug. *[Plans should add definition of "medically accepted indication" as appropriate for Medicaid-covered drugs and items.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## A. Getting your prescriptions filled

### A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website or contact Member Services *[insert if applicable: or your care coordinator]*.

### A2. Using your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy bills us for *[plans with cost-sharing, insert: our share of the cost of]* your covered prescription drug. *[Plans with no cost-sharing, delete the next sentence:]* You may need to pay the pharmacy a copay when you pick up your prescription.

If you don't have your plan ID card with you when you fill your prescription, ask the pharmacy to call us to get the necessary 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. Then you can ask us to pay you back *[insert if the plan has cost-sharing: for our share]*. **If you can't pay for the drug, contact Member Services right away.** We will do **everything we can** to help.

**Commented [BW1]:** This is a very high standard.

- To ask us to pay you back, refer to **Chapter 7** of your *Member Handbook*.
- If you need help getting a prescription filled, contact Member Services *[insert if applicable: or your care coordinator]*.

### A3. What to do if you change your network pharmacy

*[Plans in which members do not need to take any action to change their pharmacies may delete the following sentence.]* If you change pharmacies and need a prescription refill, you can *[insert as applicable: either ask to have a new prescription written by a provider or]* ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services *[insert if applicable: or your care coordinator]*.

### A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services *[insert if applicable: or your care coordinator]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy. *[Plans may insert additional information about home infusion pharmacy services in the plan's network.]*
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services. *[Plans may insert additional information about LTC pharmacy services in the plan's network.]*
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies. *[Plans may insert additional information about I/T/U pharmacy services in the plan's network.]*
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services *[insert if applicable: or your care coordinator]*.

## A6. Using mail-order services to get your drugs

*[Plans that do not offer mail-order services, replace the information in this section with the following sentence: Our plan does **not** offer mail-order services.]*

*[Include the following information only if your mail-order service is limited to a subset of all formulary drugs, adapting terminology as needed: For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition.] [Insert if plan marks mail-order drugs in formulary: Drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List.] [Insert if plan marks non-mail-order drugs in formulary: Drugs **not** available through our plan's mail-order service are marked with *[plans should indicate how these drugs are marked]* in our Drug List.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Our plan's mail-order service *[insert as appropriate: allows or requires]* you to order *[insert as appropriate: at least a <number of days>-day supply of the drug and no more than a <number of days>-day supply or up to a <number of days>-day supply or a <number of days>-day supply]*. A <number of days>-day supply has the same copay as a one-month supply.

### Filling prescriptions by mail

To get *[insert if applicable: order forms and]* information about filling your prescriptions by mail, *[insert instructions]*.

Usually, a mail-order prescription arrives within <number of days> days. *[Insert plan's process for members to get a prescription if the mail-order is delayed.]*

### Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

#### 1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

*[Plans should include the appropriate information below from the following options, based on (1) whether the plan will automatically process new prescriptions consistent with the policy described in the December 12, 2013, CMS memorandum entitled "Clarification to the 2014 Policy on Automatic Delivery of Prescriptions," and 2016 Final Call Letter and (2) whether the plan offers an optional automatic refill program consistent with the policy described in the 2020 Final Call Letter. Plan sponsors who provide automatic delivery through retail or other non-mail means have the option to either add or replace the word "ship" with "deliver" as appropriate.]*

*[For new prescriptions received directly from health care providers, insert one of the following two options.]*

*[Plan sponsors that do not automatically process new prescriptions from provider offices, insert the following:]*

#### 2. New prescriptions the pharmacy gets from your provider's office

After the pharmacy gets a prescription from a health care provider, it contacts you to find out if you want the medication filled immediately or at a later time.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allows you to stop or delay the order before *[plans with cost sharing for drugs, insert: you are billed and]* it is shipped.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

*[Plan sponsors that **do** automatically process new prescriptions from provider offices, insert the following:]*

## 2. New prescriptions the pharmacy gets from your provider's office

The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by *[insert instructions]*.

*[Plans with no cost sharing for drugs, delete the following sentence:]* If you get a prescription automatically by mail that you do not want, and you were not contacted to find out if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, contact us by *[insert instructions]*.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before *[plans with cost sharing for drugs, insert: you are billed and]* it is shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by *[insert instructions]*.

*[For refill prescriptions, insert one of the following two options.]*

*[Plans that **do not** offer a program that automatically processes refills, insert the following:]*

## 3. Refills on mail-order prescriptions



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

For refills, contact your pharmacy *[insert recommended number of days]* days before your current prescription will run out to make sure your next order is shipped to you in time.

*[Plans that do offer a program that automatically processes refills, insert the following:]*

### 3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program *[optional: called <name of auto refill program>]*. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy *[insert recommended number of days]* days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program *[optional: insert name of auto refill program instead of “our program”]* that automatically prepares mail-order refills, contact us by *[insert instructions]*.

*[All plans offering mail-order services, insert the following:]*

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. *[Insert instructions on how members should provide their communication preferences.]*

## A7. Getting a long-term supply of drugs

*[Plans that do not offer extended-day supplies, replace the information in this section with the following sentence: Our plan does not offer long-term supplies of drugs.]*

You can get a long-term 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. *[Insert if applicable: When you get a long-term supply of drugs, your copay may be lower.]*

*[Delete if the plan does not offer extended-day supplies through network pharmacies.]* Some network pharmacies allow you to get a long-term supply of maintenance drugs. A <number of days>-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call *[insert if applicable: your care coordinator or]* Member Services for more information.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Delete if plan does not offer mail-order service.] [Insert as applicable: For certain kinds of drugs, you or You] can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** [insert reference, as applicable] to learn about mail-order services.*

### **A8. Using a pharmacy not in our plan's network**

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. *[Insert as applicable: We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.]*

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

*[Plans should insert a list of situations when they cover prescriptions out of the network (e.g., during a declared disaster) and any limits on their out-of-network policies (e.g., day supply limits, use of mail-order during extended out-of-area travel, authorization or plan notification).]*

In these cases, check with *[insert if applicable: your care coordinator or]* Member Services first to find out if there's a network pharmacy nearby.

### **A9. Paying you back for a prescription**

*[Plans may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]* If you must use an out-of-network pharmacy, you must generally pay the full cost *[plans with cost-sharing, insert: instead of a copay]* when you get your prescription. You can ask us to pay you back *[plans with cost-sharing, insert: for our share of the cost]*.

To learn more about this, refer to **Chapter 7** of your *Member Handbook*.

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## **B. Our plan's Drug List**

We have a *List of Covered Drugs*. We call it the "Drug List" for short.

We select the drugs on the Drug List with the help of a team of doctors and pharmacists. The Drug List also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's Drug List when you follow the rules we explain in this chapter.

*[Plans that offer indication-based formulary design must include: If we cover a drug only for some medical conditions, we clearly identify it on our Drug List and in Medicare Plan Finder along with the specific medical conditions covered.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under *[Insert name of state Medicaid program]*.

*[Insert either of the two sentences: "Our Drug List includes brand name drugs and generic drugs." OR "Our Drug List includes brand name drugs, generic drugs, and biosimilars."]*

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

Generic drugs have the same active ingredients as brand name drugs. *[Insert if applicable: Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars.]* Generally, generic drugs *[Insert if applicable: and biosimilars]* work just as well as brand-name drugs *[Insert if applicable: or biological products]* and usually cost less. There are generic drug substitutes *[Insert if applicable: or biosimilar alternatives]* available for many brand name drugs *[Insert if applicable: and some biological products]*. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

## B2. How to find a drug on our Drug List

To find out if a drug you take is on our Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit our plan's website at <web address>. The Drug List on our website is always the most current one.
- Call *[insert if applicable: your care coordinator or]* Member Services to find out if a drug is on our Drug List or to ask for a copy of the list.

*[Plans may insert additional ways to find out if a drug is on the Drug List.]*

## B3. Drugs not on our Drug List

We don't cover all prescription drugs. Some drugs are not on our Drug List because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List.

*[Plans should remove or modify language regarding benefit exclusions when the benefits are covered by the plan under the Medicaid program.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Our plan does not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and *[insert name of state-specific Medicaid program]* drugs) cannot pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the Food and Drug Administration (FDA) or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or *[Insert name of Medicaid program]* cannot cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Outpatient drugs made by a company that says you must have tests or services done only by them

#### **B4. Drug List** *[Plans that do not have cost sharing in any tier may omit: cost sharing] tiers*

Every drug on our Drug List is in one of <number of tiers> *[Plans that do not have cost sharing in any tier may omit: cost-sharing] tiers*. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter (OTC) drugs). *[Plans that do not have cost sharing in any tier may omit the following sentence: In general, the higher the cost-sharing tier, the higher your cost for the drug.]*

*[Plans must briefly describe each tier (e.g., Cost-sharing Tier 1 includes generic drugs, or for plans with no cost sharing in any tier, Tier 1 includes generic drugs). Plans must ensure the tier label or description of the types of drugs on each tier is consistent with guidance regarding*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*generic tier labels in the 2016 Final Call Letter. Indicate which is the lowest tier and which is the highest tier.]*

To find out which *[Plans that do not have cost sharing in any tier may omit: cost-sharing]* tier your drug is in, look for the drug on our Drug List.

**Chapter 6** of your *Member Handbook* tells the amount you pay for drugs in each *[Plans that do not have cost sharing in any tier may omit: cost sharing]* tier.

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## C. Limits on some drugs

For certain prescription drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

**If there is a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug.** For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, ask us to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

*[Plans should include only the forms of utilization management the plan uses. Plans delete any they don't use and renumber the list accordingly.]*

### 1. Limiting use of a brand name drug when a generic version is available

Generally, a generic drug works the same as a brand name drug and usually costs less. *[Insert as applicable: In most cases, if or If]* there is a generic version of a brand name drug available, our network pharmacies give you the generic version.

- We usually do not pay for the brand name drug when there is an available generic version.
- However, if your provider *[insert as applicable: told us the medical reason that the generic drug won't work for you or wrote "No substitutions" on your prescription for a brand name drug or told us the medical reason that the generic drug or other covered drugs that treat the same condition will work for you]*, then we cover the brand name drug.
- *[Plans that offer all drugs at \$0 cost-sharing, delete the following sentence:]* Your copay may be greater for the brand name drug than for the generic drug.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## 2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from our plan before you fill your prescription. If you don't get approval, we may not cover the drug.

## 3. Trying a different drug first

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A does **not** work for you, then we cover Drug B. This is called step therapy.

## 4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services or check our website at <web address>. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to Chapter 9 of the *Member Handbook*.

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## D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our Drug List. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above [\[insert reference, as applicable\]](#), some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

### D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our Drug List or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**To get a temporary supply of a drug, you must meet the two rules below:**

1. The drug you've been taking:
  - Is no longer on our Drug List **or**
  - Was never on our Drug List **or**
  - Is now limited in some way.
2. You must be in one of these situations:
  - *[Plans omit this scenario if the plan allows current members to ask for formulary exceptions in advance for the following year. Plans omit this scenario if the plan was not operating in the prior year.]* You were in our plan last year.
    - We cover a temporary supply of your drug **during the first [insert time period (must be at least 90 days)] days of the calendar year.**
    - This temporary supply is for up to *[insert supply limit (must be the number of days in plan's one-month supply)]* days.
    - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of *[insert supply limit (must be the number of days in plan's one-month supply)]* days of medication. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
  - You are new to our plan.
    - We cover a temporary supply of your drug **during the first [insert time period (must be at least 90 days)] days of your membership in our plan.**
    - This temporary supply is for up to *[insert supply limit (must be the number of days in plan's one-month supply)]* days.
    - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of *[insert supply limit (must be the number of days in plan's one-month supply)]* days of medication. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

**Commented [BW2]:** Would like this to match the continuity of care period for new members if possible, and definitely not to vary across plans.

In our state right now, it must be 180 days. While 180 is greater than 90, how can we communicate to our plans that it must be 180 and is not variable across plans?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- You have been in our plan for more than *[insert time period (must be at least 90 days)]* days, live in a long-term care facility, and need a supply right away.
  - We cover one *[insert supply limit (must be at least a 31-day supply)]*-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - *[If applicable, plans insert their transition policy for current members with changes to their level of care.]*

## D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

**OR**

- Ask for an exception.

You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our Drug List or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

*[Plans that do not allow current members to ask for an exception prior to the beginning of the following contract year may omit this paragraph.]*

## D3. Asking for an exception

If a drug you take will be taken off our Drug List or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you need help asking for an exception, contact Member Services *[insert if applicable: or your care coordinator]*.

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## E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our Drug List during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year** unless:

- A new, cheaper drug comes on the market that works as well as a drug on our Drug List now, **or**
- We learn that a drug is not safe, **or**
- A drug is removed from the market.

To get more information on what happens when our Drug List changes, you can always:

- Check our current Drug List online at <web address> **or**
- Call Member Services at the number at the bottom of the page to check our current Drug List.

Some changes to our Drug List happen **immediately**. For example:

- *[Plans that otherwise meet all requirements and want the option to immediately replace brand name drugs with their generic equivalents must provide the following advance general notice of changes: **A new generic drug becomes available.** Sometimes, a new generic drug comes on the market that works as well as a brand name drug on our Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug stays the same *[insert if applicable, for example, if the plan's Drug List has differential cost-sharing for some generics: or will be lower.]**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we send you information about the specific change we made once it happens.
- You or your provider can ask for an “exception” from these changes. We send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of your *Member Handbook* for more information on exceptions.]
- **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug’s manufacturer takes a drug off the market, we take it off our Drug List. If you are taking the drug, we tell you. *[Plans include information advising members what to do after they are notified (e.g., contact the prescribing doctor, etc.).]*

**We may make other changes that affect the drugs you take.** We tell you in advance about these other changes to our Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- *[Plans that want the option to immediately substitute a new generic drug, insert: We add a generic drug that is not new to the market and*
  - Replace a brand name drug currently on our Drug List **or**
  - Change the coverage rules or limits for the brand name drug.]
- *[Plans that are not making immediate generic substitutions insert: We add a generic drug and*
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.]

When these changes happen, we:

- Tell you at least 30 days before we make the change to our Drug List **or**
- Let you know and give you a *[insert supply limit (must be at least the number of days in the plan’s one-month supply)]*-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on our Drug List you can take instead **or**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you should ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

**We may make changes to drugs you take that do not affect you now.** For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally do not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking *[insert if applicable: , increase what you pay for the drug,]* or limit its use, then the change does not affect your use of the drug *[insert if applicable: or what you pay for the drug]* for the rest of the year.

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## F. Drug coverage in special cases

### F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you are admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your prescription drugs during your stay. You will not pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

*[Plans with no cost-sharing, delete this paragraph:]* To learn more about drug coverage and what you pay, refer to **Chapter 6** of your *Member Handbook*.

### F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has their own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not or if you need more information, contact Member Services.

### F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug that your hospice does not cover because it is not related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of your *Member Handbook* for more information about the hospice benefit.

---

## G. Programs on drug safety and managing drugs

### G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- May not be needed because you take another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we work with your provider to correct the problem.

### G2. Programs to help you manage your drugs

*[If plan has more than one medication therapy management program update language to reflect this.]* Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

Then, they will give you:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you do not want to be in the program, let us know, and we will take you out of it.

If you have questions about these programs, contact Member Services [\[insert if applicable: or your care coordinator\]](#).

### G3. Drug management program for safe use of opioid medications

Our plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid [\[insert if applicable: or benzodiazepine\]](#) medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications from [\[insert: a certain pharmacy or certain pharmacies\]](#) and/or from [\[insert: a certain doctor or certain doctors\]](#)
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter explains the limitations we think should apply.

**You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know.** If we decide to limit your coverage for



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization. To learn more about appeals and the Independent Review Organization, refer to **Chapter 9** of your *Member Handbook*.)

The DMP may not apply to you if you:

- Have certain medical conditions, such as cancer or sickle cell disease,
- Are getting hospice, palliative, or end-of-life care, **or**
- Live in a long-term care facility.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.

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<Plan name> MEMBER HANDBOOK

## Chapter 6: What you pay for your Medicare and *[Insert name of Medicaid program]* Medicaid prescription drugs

### Introduction

This chapter tells what you pay for your outpatient prescription drugs. By “drugs,” we mean:

- Medicare Part D prescription drugs, **and**
- Drugs and items covered under Medicaid, **and**
- Drugs and items covered by our plan as additional benefits.

Because you are eligible for *[insert state-specific name of Medicaid program]*, you get “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs. *[Plans who have \$0 cost sharing for all Medicare Part D drugs should remove the remaining language in this paragraph.]* We *[insert as appropriate: have included or sent you]* a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

**Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

To learn more about prescription drugs, you can look in these places:

- Our *List of Covered Drugs*.
  - We call this the “Drug List.” It tells you:
    - Which drugs we pay for



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Which of the <number of tiers> *[Plans that do not have cost sharing in any tier may omit: cost-sharing]* tiers each drug is in
- If there are any limits on the drugs
- If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at <web address>.
- **Chapter 5** of your *Member Handbook*.
  - It tells how to get your outpatient prescription drugs through our plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.
- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of your *Member Handbook* more information about network pharmacies.

*[Plans with no cost-sharing for all outpatient drugs, delete Sections D, E, F, and G and change section H to section D.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. The *Explanation of Benefits* (EOB)

*[Plans with a single payment stage (i.e., no cost-sharing differences between the Initial Coverage Stage and the Catastrophic Coverage Stage), modify this section as necessary.]*

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount we pay.

When you get prescription drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB is not a bill. The EOB has more information about the drugs you take *[insert, as applicable: such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options]*. The EOB includes:

- **Information for the month.** The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **Year-to-date information.** This is your total drug costs and total payments made since January 1.
- **Drug price information.** This is the total price of the drug and any percentage change in the drug price since the first fill.
- **Lower cost alternatives.** When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count towards your total out-of-pocket costs.
- *[Insert only if the plan pays for OTC drugs as part of its administrative costs under Medicare Part D, rather than as a Medicaid benefit: We also pay for some over-the-counter drugs. You do not have to pay anything for these drugs.]*
- To find out which drugs our plan covers, refer to our Drug List. *[Insert if applicable: In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under <insert state-specific name of Medicaid program>. These drugs are included in the Drug List.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

### 1. Use your plan ID card.

Show your plan ID card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

### 2. Make sure we have the information we need.

Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for *[insert if plan has cost-sharing: our share of the cost of]* the drug.

Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

For more information about asking us to pay you back for *[insert if plan has cost-sharing: our share of the cost of]* a drug, refer to **Chapter 7** of your *Member Handbook*.

### 3. Send us information about payments others have made 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, the Indian Health Service, and most charities count toward your out-of-pocket costs. *[Plans should delete the rest of this paragraph if they cover all Medicare Part D drugs at \$0 cost-sharing:]* This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

### 4. Check the EOBs we send you.

- When you get an EOB in the mail, make sure it is complete and correct.

**Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

For more information, you can call <plan name> Member Services or read the <plan name> *Member Handbook*. *[Plans must include information about how to access the Member Handbook on the plan's website.]*

### What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this *Explanation of Benefits*, please call us at <plan name> Member Services. *[If applicable: You can also find answers to many questions on our website: <MMP web address>.]*

### What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at <plan name> Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- *[Plans may also insert additional State-based resources for reporting fraud.]*

If you think something is wrong or missing, or if you have any questions, call Member Services. *[Plans that allow members to manage this information online may describe that option here.]* Keep these EOBs. They are an important record of your drug expenses.

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### C. *[Plans with two payment stages, insert: Drug Payment Stages for Medicare Part D drugs] [Plans with one payment stage, insert: You pay nothing for a one-month [insert if applicable: or long-term] supply of drugs]*

*[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following sentence: With our plan, you pay nothing for covered drugs as long as you follow our rules.]*

*[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), include the following paragraph and table.]*

There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Stage 1: Initial Coverage Stage                                                                                                                                                                             | Stage 2: Catastrophic Coverage Stage                                                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay.</p> <p>You begin in this stage when you fill your first prescription of the year.</p> | <p>During this stage, we pay all of the costs of your drugs through &lt;end date&gt;.</p> <p>You begin this stage when you have paid a certain amount of out-of-pocket costs.</p> |

*[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following information up to Section D.]*

**C1. Our** *[Plans that do not have cost sharing in any tier may omit: **cost-sharing** tiers]*

*[Plans must provide an explanation of tiers; refer to the examples below. Plans must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter.]*

*[Plans that have cost sharing in any tier include:* Cost-sharing tiers are groups of drugs with the same copay. Every drug on our Drug List is in one of <number of tiers> cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our Drug List.

*If a plan has no cost sharing for one or more tiers of drugs, the plan should modify the cost sharing information accordingly. Include examples such as the following:*

- Tier 1 drugs have the lowest copay. They may be generic drugs or non-Medicare drugs that are covered by Medicaid. The copay is from <amount> to <amount>, depending on your income.
- Tier 2 drugs have a medium copay. They are brand name drugs. The copay is from <amount> to <amount>, depending on your income.
- Tier 3 drugs have the highest copay. The copay is <amount>.]

*[Plans that do not have cost sharing in any tier include:* Tiers are groups of drugs on our plan's Drug List. Every drug on our Drug List is in one of <number of tiers> tiers. You have no copays for prescription and OTC drugs on our Drug List. To find the tiers for your drugs, refer to our Drug List.

*Include examples such as the following:*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- Tier 1 drugs are generic drugs.
- Tier 2 drugs are brand name drugs.]

## C2. Your pharmacy choices

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

- a network pharmacy, **or**
- an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of your *Member Handbook* to find out when we do that. Refer to **Chapter 9** of the *Member Handbook* to learn about how to file an appeal if you are told a drug will not be covered.

To learn more about these pharmacy choices, refer to **Chapter 5** of your *Member Handbook* and our *Provider and Pharmacy Directory*.

## C3. Getting a long-term supply of a drug

*[Plans that do not offer extended supplies, delete the following two paragraphs:]*

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is *[insert if applicable: up to]* a <number of days>-day supply. *[Plans with cost-sharing, insert: It costs you the same as a one-month supply.] [Plans with no cost-sharing, insert: There is no cost to you for a long-term supply.]*

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Member Handbook* or our *Provider and Pharmacy Directory*.

## C4. What you pay

*[Plans that have copays on at least one tier must include the following language:]* You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Member Services to find out how much your copay is for any covered drug.

**Your share of the cost when you get a one-month *[insert if applicable: or long-term]* supply of a covered prescription drug from:**

*[Plans may delete columns and modify the table as necessary to reflect the plan’s prescription drug coverage. Include all possible copay amounts (not just the high/low ranges) – i.e., all three possible copay amounts for a tier in which LIS cost sharing applies – in the chart, as well as a statement that the copays for prescription drugs may vary based on the level of Extra Help the member gets (if the plan charges copays for any of its Medicare Part D drugs). Modify the chart as necessary to include \$0 copays for non-Medicare covered drugs. Plans must ensure the tier*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter.]*

*[Plans should add or remove tiers as necessary. Plans should remove references to “cost sharing” to describe tiers if they do not have cost sharing in any tier. If mail-order is not available for certain tiers, plans should insert the following text in the cost-sharing cell: Mail-order is not available for drugs in [insert tier].]*

|                                                                                           | <b>A network pharmacy</b>                          | <b>Our plan's mail-order service</b>               | <b>A network long-term care pharmacy</b> | <b>An out-of-network pharmacy</b>                                                                                                                |
|-------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                           | A one-month or up to a <number of days>-day supply | A one-month or up to a <number of days>-day supply | Up to a <number of days>-day supply      | Up to a <number of days>-day supply. Coverage is limited to certain cases. Refer to <b>Chapter 5</b> of your <i>Member Handbook</i> for details. |
| <b>Cost-sharing Tier 1</b><br><br>( <i>[Insert description; e.g., “generic drugs.”]</i> ) | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 2</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 3</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 4</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |

For information about which pharmacies can give you long-term supplies, refer to our plan's *Provider and Pharmacy Directory*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## D. Stage 1: The Initial Coverage Stage *[Plans with one coverage stage should delete this section]*

During the Initial Coverage Stage, we pay a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on the cost-sharing tier the drug is in and where you get it.

*[Plans must provide an explanation of tiers; refer to the examples below. Plans have flexibility to describe their tier model but must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter. Plans may also edit or delete language regarding Medicaid based on Medicaid coverage.]*

*[Plans that have cost sharing in any tier include:* Cost-sharing tiers are groups of drugs with the same copay. Every drug on our plan's Drug List is in one of <number of tiers> cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our Drug List.

- Tier 1 drugs have the lowest copay. They may be generic drugs or non-Medicare drugs that *[Insert state-specific name of Medicaid program]* covers. The copay is from <amount> to <amount>, depending on your income.
- Tier 2 drugs have a medium copay. They are brand name drugs. The copay is from <amount> to <amount>, depending on your income.
- Tier 3 drugs have the highest copay. The copay is <amount>.]

*[Plans that do not have cost sharing in any tier include:* Tiers are groups of drugs on our plan's Drug List. Every drug on our Drug List is in one of <number of tiers> tiers. You have no copay for prescription and OTC drugs on our Drug List. To find the tiers for your drugs, refer to our Drug List.

*Include examples such as the following:*

- Tier 1 drugs are generic drugs.
- Tier 2 drugs are brand name drugs.]

### D1. Your pharmacy choices

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

- A network pharmacy **or**
- An out-of-network pharmacy.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of your *Member Handbook* to find out when we do that.

To learn more about these choices, refer to **Chapter 5** of your *Member Handbook* and to our *Provider and Pharmacy Directory*.

## D2. Getting a long-term supply of a drug

*[Plans that do not offer extended supplies, delete the following two paragraphs:]*

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is *[insert if applicable: up to]* a <number of days>-day supply. *[Plans with cost-sharing, insert: It costs you the same as a one-month supply.] [Plans with no cost-sharing, insert: There is no cost to you for a long-term supply.]*

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Member Handbook* or our plan’s *Provider and Pharmacy Directory*.

## D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Member Services to find out how much your copay is for any covered drug.

**Your share of the cost when you get a one-month *[insert if applicable: or long-term]* supply of a covered prescription drug from:**

*[Plans may delete columns and modify the table as necessary to reflect the plan’s prescription drug coverage. Include all possible copay amounts (not just the high/low ranges) – i.e., all three possible copay amounts for a tier in which LIS cost sharing applies – in the chart, as well as a statement that the copays for prescription drugs may vary based on the level of Extra Help the member gets. Plans must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter.]*

*[Plans should add or remove tiers as necessary. Plans should remove references to “cost sharing” to describe tiers if they do not have cost sharing in any tier. If mail-order is not available for certain tiers, plans should insert the following text in the cost-sharing cell: Mail-order is not available for drugs in *[insert tier]*.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                           | <b>A network pharmacy</b>                          | <b>Our plan's mail-order service</b>               | <b>A network long-term care pharmacy</b> | <b>An out-of-network pharmacy</b>                                                                                                                |
|-------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                           | A one-month or up to a <number of days>-day supply | A one-month or up to a <number of days>-day supply | Up to a <number of days>-day supply      | Up to a <number of days>-day supply. Coverage is limited to certain cases. Refer to <b>Chapter 5</b> of your <i>Member Handbook</i> for details. |
| <b>Cost-sharing Tier 1</b><br><br>( <i>[Insert description; e.g., "generic drugs."]</i> ) | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 2</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 3</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |
| <b>Cost-sharing Tier 4</b><br><br>( <i>[Insert description.]</i> )                        | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                          | <i>[Insert copay(s).]</i>                | <i>[Insert copay(s).]</i>                                                                                                                        |

For information about which pharmacies can give you long-term supplies, refer to our *Provider and Pharmacy Directory*.

#### D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Your Explanation of Benefits (EOB) helps you keep track of how much you have paid for your drugs during the year. We let you know if you reach the *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]* limit. Many people do not reach it in a year.

---

### **E. Stage 2: The Catastrophic Coverage Stage** *[Plans with one coverage stage should delete this section]*

When you reach the out-of-pocket limit of [*\$<TrOOP amount>*] for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, our plan pays all of the costs for your Medicare drugs.

---

### **F. Your drug costs if your doctor prescribes less than a full month's supply** *[Plans with no Medicare Part D drug cost-sharing should delete this section]*

*[Insert as appropriate: Usually or In some cases]*, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects).
- If your doctor agrees, you do not pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. 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.

- *[Plans may revise the information in this paragraph to reflect the appropriate number of days for their one-month supplies as well as the cost-sharing amount in the example.]* Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment is less than \$0.05 per day multiplied by 7 days, for a total payment less than \$0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Better plan when to refill your drugs,
- Coordinate refills with other drugs you take, **and**
- Take fewer trips to the pharmacy.

## G. Prescription cost-sharing assistance for persons with HIV/AIDS

*[Plans with no Medicare Part D drug cost-sharing delete this section]*

### G1. The AIDS Drug Assistance Program (ADAP)

The AIDS Drug Assistance Program (ADAP) helps eligible individuals living with HIV/AIDS access life-saving HIV medications. Outpatient Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the *[insert name of state-specific department]* for individuals enrolled in ADAP.

### G2. If you are not enrolled in ADAP

For information on eligibility criteria, covered drugs, or how to enroll in the program, call *[insert phone number]* or check the ADAP website at *[insert website address]*.

### G3. If you are enrolled in ADAP

ADAP can continue to provide ADAP clients with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. To be sure you continue getting this assistance, notify *[insert description of who to notify]* of any changes in your Medicare Part D plan name or policy number. If you need help finding the nearest ADAP enrollment site and/or enrollment worker, call *[insert phone number]* or check the website listed above.

**Commented [BW1]:** We don't think any of our members will be eligible for ADAP because in our state, Medicaid eligibility seems to disqualify members from ADAP. Can we make this section optional? See this website: <https://scdhec.gov/aids-drug-assistance-program>

Our HIV/AIDS waiver does offer some additional covered prescriptions to members with HIV/AIDS, so if this section is not optional, could we modify it to include details about the waiver instead?

## H. Vaccinations

*[Plans may revise this section as needed.]*

We cover Medicare Part D vaccines. There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

### H1. What you need to know before you get a vaccination

*[Plans may revise this section as needed.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We recommend that you call Member Services if you plan to get a vaccination.

- We can tell you about how our plan covers your vaccination *[insert if the plan has cost-sharing: and explain your share of the cost]*.
- *[Insert if applicable: We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider work with us to ensure that you have no upfront costs for a Medicare Part D vaccine.]*

*[Plans that do not charge any Medicare Part D vaccine copays may delete the following section.]*

## H2. What you pay for a vaccination covered by Medicare Part D

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. *[Insert if applicable: You may have to pay a copay for Medicare Part D vaccines.]*

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
  - You pay *[insert as applicable: nothing or a copay]* for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
  - You pay *[insert as applicable: nothing or a copay]* to the doctor for the vaccine.
  - Our plan pays for the cost of giving you the shot.
  - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay *[insert as applicable: nothing or a copay]* for the vaccine.
3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
  - You pay *[insert as applicable: nothing or a copay]* for the vaccine.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- Our plan pays for the cost of giving you the shot.

*[Insert any additional information about your coverage of vaccinations.]*



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.

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<Plan name> MEMBER HANDBOOK

## Chapter 7: Asking us to pay *[plans with cost sharing, insert: our share of]* a bill you got for covered services or drugs

### Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction *[insert reference, as applicable]* appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans with an arrangement with the State may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits. Plans may not revise the chapter or section headings except as indicated.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## A. Asking us to pay for your services or drugs

[Plans with cost sharing delete the next sentence.] You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We do not allow <plan name> providers to bill you for these services [insert as applicable: or drugs]. We pay our providers directly, and we protect you from any charges.

**If you get a bill for [plans with cost sharing insert: the full cost of] health care or drugs, do not pay the bill and send the bill to us.** To send us a bill, refer to [plans may insert reference, as applicable].

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid [plans with cost sharing, insert: more than your share of the cost; plans with no cost sharing, insert: the bill], it is your right to be paid back.
  - If you paid for services covered by Medicare, we will pay you back.
  - If you paid for services covered by [insert name of state-specific Medicaid program] we can't pay you back, but the provider will. Member services or [insert the term for your care coordinator and/or ombudsman, if applicable] can help you contact the provider's office. Refer to the bottom of the page for the member services phone number.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services [insert if appropriate: or your care coordinator] if you have any questions. If [plans with cost sharing insert: you do not know what you should have paid, or if] you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

### 1. When you get emergency or urgently needed health care from an out-of-network provider

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back [plans with cost sharing insert: for our share of the cost]. Send us the bill and proof of any payment you made.

**Commented [BW1]:** Currently, our handbooks refer to member services or our program ombudsman. Understanding that the role of the ombudsman is still a bit TBD going forward, it would still be nice to include the option in the instructions



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - If the provider should be paid, we will pay the provider directly.
  - If you already paid *[plans with cost sharing insert: more than your share of the cost]* for the Medicare service, we will *[plans with cost sharing insert: figure out how much you owed and]* pay you back *[plans with cost sharing insert: for our share of the cost]*.

## 2. When a network provider sends you a bill

Network providers must always bill us, it's important to show your plan ID card when you get any services or prescriptions. But sometimes they make mistakes, and ask you to pay for your services or more than your share of the costs. **Call Member Services** *[insert if appropriate: or your care coordinator]* at the number at the bottom of this page **if you get any bills.**

- *[Plans with no cost sharing, insert: Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.]*
- *[Plans with cost sharing, insert: As a plan member, you only pay the copay when you get services we cover. We don't allow providers to bill you more than this amount. This is true even if we pay the provider less than the provider charged for a service. Even if we decide not to pay for some charges, you still do not pay them.]*
- Whenever you get a bill from a network provider *[plans with cost sharing insert: that you think is more than you should pay]*, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, *[plans with cost sharing insert: but you feel that you paid too much.]* send us the bill and proof of any payment you made. We will pay you back *[insert as appropriate: for your covered services or for the difference between the amount you paid and the amount you owed under our plan]*.

## 3. If you are retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It **may have even been last year.**)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.

**Commented [BW2]:** We flagged this for discussion within our state; we hope that CMS will allow us the freedom to set retro enrollment policies that align with what we currently use in our Medicaid managed care program.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Send us the bill and proof of any payment you made.

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, ~~will we~~ *will* cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back *[plans with cost sharing insert: for our share of the cost]*.
- Refer to **Chapter 5** of your *Member Handbook* to learn more about out-of-network pharmacies.

**Commented [BW3]:** Grammar item. "In only a few cases, we will" (with comma) or, "In only a few cases will we" (no comma).

#### 5. When you pay the full *[insert if only applicable to Medicare Part D: Medicare Part D]* prescription cost because you don't have your plan ID card with you

If you don't have your plan ID card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your plan ID card.
- Send us a copy of your receipt when you ask us to pay you back *[plans with cost sharing insert: for our share of the cost]*.

#### 6. When you pay the full *[insert if only applicable to Medicare Part D: Medicare Part D]* prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Member Handbook*).
  - If you and your doctor or other prescriber think you need the drug right away, (within 72 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your *Member Handbook*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for *[plans with cost sharing insert: our share of the cost of]* the drug.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide the service or drug should be covered, we pay for *[insert if the plan has cost sharing: our share of the cost of]* it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your *Member Handbook*.

---

## B. Sending us a request for payment

*[Plans may edit this section to include a second address if they use different addresses for processing health care and drug claims.]*

*[Plans may edit this section as necessary to describe their claims process.]*

Send us your bill and proof of any payment you made for Medicare services *[Insert if allowed: or call us]*. Proof of payment can be a copy of the check you wrote or a receipt from the provider.

**It's a good idea to make a copy of your bill and receipts for your records.** *[Plans with care coordinators who can assist, insert: You can ask your care coordinator for help.] [Insert if applicable: You must send your information to us within [insert timeframe] of the date you received the service, item, or drug.]*

*[If the plan has a specific form for requesting payment, insert the following language: To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.]*

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website (<web address>), or you can call Member Services and ask for the form.]

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

*[Insert address.]*

*[If the plan allows members to submit oral payment requests, insert the following language:*

*You may also call us to ask payment.] [Plans include all applicable numbers and days and hours of operation.]*

*[Insert if applicable: You must submit your claim to us within <number of days> days of the date you got the service, item, or drug.]*

---

## C. Coverage decisions



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug.** We also decide the amount of money, if any, you must pay.

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay *[plans with cost sharing insert: our share of the cost]* for it. If you already paid for the service or drug, we will mail you a check for *[insert as applicable: what you paid or our share of the cost]*. If you haven't paid, we will pay the provider directly.

**Chapter 3** of your *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of your *Member Handbook* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for *[plans with cost sharing insert: our share of the cost of]* the service or drug, we will send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9 *[insert reference, as applicable]*.

---

## D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making an appeal." You can also make an appeal if you don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of your *Member Handbook*: *[plans may insert reference, as applicable]*.

- To make an appeal about getting paid back for a health care service, refer to **Section F** *[insert reference, as applicable]*.
- To make an appeal about getting paid back for a drug, refer to **Section G** *[insert reference, as applicable]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.

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<Plan name> MEMBER HANDBOOK

## Chapter 8: Your rights and responsibilities

### Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Note: Plans may add to or revise this chapter as needed to reflect NCQA required language or language required by state Medicaid program.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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## A. Your right to get services and information in a way that meets your needs

*[Plans may edit the section heading and content to reflect the types of alternate format materials available to plan members. Plans may not edit references to language except as noted below.]*

*[Plans must insert a translation of this section in all languages that meet the language threshold.]*

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call *[insert if applicable: your care coordinator or]* Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials *[insert if required to provide materials in any non-English languages: in languages other than English and]* in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call or write to *[Insert Plan name, address, and phone number]*. *[Plans specifically state which languages are offered. Plans also simply describe:*
  - *how they request a member's preferred language other than English and/or alternate format,*
  - *how they keep the member's information as a standing request for future mailings and communications so the member doesn't need to make a separate request each time, and*
  - *how a member can change a standing request for preferred language and/or format.]*

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- *[Plans should insert information about filing a complaint with Medicaid. Also, include any other state-required offices.]*
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## B. Our responsibility for your timely access to covered services and drugs

*[Plans may edit this section to add specific requirements for minimum access to care and remedies.]*

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Member Handbook*.
  - Call *[insert if applicable: your care coordinator or]* Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- *[Plans may edit this sentence to add other types of providers that members may use without a referral.]* Women have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that is not your PCP. *[If applicable, replace the previous sentences with: We do not require you to get referrals. or We do not require you to use network providers.]*
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Member Handbook*.
- *[Plans should include any additional state requirements regarding covered services or drugs here.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Chapter 9** of your *Member Handbook* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

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## C. Our responsibility to protect your personal health information (PHI)

We protect your personal health information (PHI) as required by federal and state laws.

Your PHI includes information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights to when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

### C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws. *[Plans may insert similar information, as appropriate, about sharing medical records with Medicaid]*

### C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. *[Insert if applicable: We may charge you a fee for making a copy of your medical records.]*
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you have questions or concerns about the privacy of your PHI, call Member Services.

*[Plans may insert custom privacy practices.]*

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## D. Our responsibility to give you information

*[Plans may edit the section to reflect the types of alternate format materials available to plan members and/or languages primarily spoken in the plan's service area.]*

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call us at <phone number>. This is a free service to you. *[Plans must insert information about the availability of written materials in languages other than English, stating specifically which languages are offered.]* We can also give you information in large print, braille, or audio. *[If applicable, plans insert information about the availability of written materials in other formats.]*

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of your *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Member Handbook*) covered by our plan
  - limits to your coverage and drugs



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Member Handbook*), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

---

## E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of your *Member Handbook*.

---

## F. Your right to leave our plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another MA plan.
- Refer to **Chapter 10** of your *Member Handbook*:
  - For more information about when you can join a new MA or prescription drug benefit plan.
  - For information about how you will get your [\[Insert name of Medicaid program\]](#) benefits if you leave our plan.

---

## G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

### G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Member Handbook* tells how to ask us for a coverage decision.

## G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

*[Note: Plans that would like to provide members with state-specific information about advance directives may do so. Include contact information for the appropriate state agency.]*

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you.**
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do **not** want.

The legal document that you use to give your directions is called an “advance directive.” There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You are not required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. *[Insert if applicable: You can also contact Member Services to ask for the form.]*
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- *[Insert any additional state-specific requirements as directed by the state.]*

Call Member Services for more information.

### G3. What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with *[plans insert the name and contact information of the applicable state-specific agency]*.

---

## H. Your right to make complaints and ask us to reconsider our decisions

**Chapter 9** of your *Member Handbook* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

### H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it is **not** about discrimination for reasons listed in **Chapter 11** of your *Member Handbook* – or you want more information about your rights, you can call:

- Member Services at *<insert phone and TTY numbers>*.
- The *[insert name of state-specific SHIP]* program at *[insert phone number]*. For more details about *[insert name of state-specific SHIP]*, refer to Chapter 2 *[insert reference, as applicable]*.
- *[Insert this section if applicable: The Ombudsman Program at <phone number>. For more details about this program, refer to Chapter 2 of your Member Handbook.]*

Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at [www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf](http://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf).)

*[If applicable, plans should insert additional contact information, such as for the state Medicaid agency.]*

---

## I. Your responsibilities as a plan member

*[Plans may modify this section to include additional member responsibilities. Plans may add information about estate recovery and other requirements mandated by the state.]*

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your *Member Handbook*. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your plan ID card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- *[Plans should edit the bullets below as needed to reflect the costs applicable to their members.]* **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most *<plan name>* members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.
  - *[Delete this bullet if the plan does not have cost sharing:]* For some of your *[insert if the plan has cost sharing for long-term services and supports: long-term services and supports [or drugs]]* covered by the plan, you must pay your share of the cost when you get the *[insert if the plan has cost sharing for services: service [or drug]]*. This will be a *[insert as appropriate: [copayment/copay] (a fixed amount) or coinsurance (a percentage of the total cost)]*. *[Insert if the plan has cost sharing for long-term services and supports: Chapter 4 [plans may insert reference, as applicable] tells what you must pay for your long-term services and supports.] Chapter 6 [plans may insert reference, as applicable] tells what you must pay for your drugs.*

**Commented [BW1]:** There was a reference to coinsurance in Chapter 2 in 2023, but it was removed in this set of documents. Be sure these two chapters align.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (Note: If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to Chapter 9 [plans may insert reference, as applicable] to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call [insert if applicable: your care coordinator or] Member Services.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Member Handbook* tells about our service area.
  - We can help you find out if you're moving outside our service area. [Plans that do not offer plans outside the service area may delete the following sentence:] During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and [Insert state-specific name of Medicaid program] your new address when you move. Refer to **Chapter 2** of your *Member Handbook* for phone numbers for Medicare and [Insert name of state-specific Medicaid program].
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Call [insert if applicable: your care coordinator or] Member Services for help if you have questions or concerns.**

**Commented [BW2]:** For 2023 and previous years, we have noted that members may face estate recovery in some circumstances, and we have included that information as a bullet before this one. Depending on program design, it is possible this might continue into 2024; is it OK for the handbook to be silent on the issue, or should the instructions be modified to allow states to insert it here if needed?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.*

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<Plan name> MEMBER HANDBOOK

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

*[Plans that integrate the description of Medicare and Medicaid processes must revise the sections of this chapter as needed to clearly describe the appeals and grievance processes.]*

**Commented [BW1]:** These edits are potentially extensive; how should states communicate these edits with plans to ensure consistency?

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[In cases where members should contact a department other than Member Services (for example, a grievance and appeals unit), plans should revise the instructions to provide the appropriate contact information.]*

### Introduction

This chapter has information about your rights. Read this chapter to find out what to do if: *[Add any additional language for state-specific Medicaid information]*

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

*[Plans must include information about the ombudsman program, if directed by the state.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

**Commented [BW2]:** Our state has always had a paragraph here referring people to our ombudsman as a resource for appeals. Assuming they remain in that role for 2024, should we add an instruction here or is this addressed adequately elsewhere?

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints**; also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

### A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” instead of “Independent Review Entity”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

---

## B. Where to get help

### B1. For more information and help

Sometimes it's confusing to start or follow the process for dealing with a problem. This can be especially true if you don't feel well or have limited energy. Other times, you may not have the information you need to take the next step.

**Help from the** *[Insert state-specific name of the SHIP program]*

You can call the *[insert state-specific name of the SHIP program]*. *[insert state-specific name of the SHIP program]* counselors can answer your questions and help you understand what to do about your problem. *[Insert state-specific name of the SHIP program]* is not connected with us or with any insurance company or health plan. *[Insert state-specific name of the SHIP program]* has trained counselors in every county, and services are free. The *[insert state-specific name of the SHIP program]* phone number is *[insert phone number]*.



---

**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)).

### Help and information from *[insert name of state-specific Medicaid program]*

*[Insert contact information for the state Medicaid agency. Insert similar sections for the QIO or ombudsman, as applicable.]*

**Commented [BW3]:** Thank you; they are existing resources for our members.

---

## C. Understanding Medicare and *[insert name of state-specific Medicaid program]* complaints and appeals in our plan

You have Medicare and *[insert name of state-specific Medicaid program]*. Information in this chapter applies to **all** of your Medicare and *[insert name of state-specific Medicaid program]* benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and *[insert state-specific name of Medicaid program]* processes.

Sometimes Medicare and *[insert state-specific name of Medicaid program]* processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a *[insert state-specific name of Medicaid program]* benefit. **Section F4** explains these situations.

---

## D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The chart below helps you find the right section of this chapter for problems or complaints.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



|                                                                                                                                                                                                                                                                               |                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <b>Is your problem or concern about your benefits or coverage?</b><br><br>This includes problems about whether particular medical care or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs. |                                                                                                                                 |
| <b>Yes.</b><br>My problem is about<br>benefits or coverage.<br><br>Refer to <b>Section E</b> , "Coverage decisions<br>and appeals."                                                                                                                                           | <b>No.</b><br>My problem is not about<br>benefits or coverage.<br><br>Refer to <b>Section K</b> , "How to make a<br>complaint." |

## E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

### E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. We make a coverage decision whenever we decide what is covered for you and how much we pay. For example, your network doctor makes a favorable coverage decision for you whenever you get medical care from them or if they refer you to a medical specialist.

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or [\[insert state-specific name of Medicaid program\]](#). If you disagree with this coverage decision, you can make an appeal.

### E2. Appeals

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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 if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter *[insert reference, as applicable]*, you can ask for an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare medical service or item or Part B drugs, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

### E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- *[Insert name of SHIP program and contact information.]*
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

*[Insert any additional state-specific references for assistance with coverage decisions and appeals as applicable.]*

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the “Appointment of Representative” form. You can also get the form by visiting [www.cms.gov/Medicare/CMS-](http://www.cms.gov/Medicare/CMS-)



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

[Forms/CMS-Forms/downloads/cms1696.pdf](#) [plans may also insert: or on our website at <web address or link to form>]. You must give us a copy of the signed form.

#### E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, “Medical care” [insert reference, as applicable]
- **Section G**, “Medicare Part D prescription drugs” [insert reference, as applicable]
- **Section H**, “Asking us to cover a longer hospital stay” [insert reference, as applicable]
- **Section I**, “Asking us to continue covering certain medical services [insert reference, as applicable] (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you’re not sure which section to use, call Member Services at the numbers at the bottom of the page. [Plans may insert additional resources and contact information (e.g., SHIP, Ombudsman Program).]

---

### F. Medical care

[Plans may update the heading and terms such as “medical care” throughout to account for Medicaid services such as behavioral health and long-term care services as directed by the state.]

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for [insert if plan has cost sharing: our share of the cost of] your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of your *Member Handbook*. We generally refer to “medical care coverage” or “medical care” in the rest of this section. The term “medical care” includes medical services and items as well as Medicare Part B prescription drugs which are drugs administered by your doctor or health care professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

#### F1. Using this section

This section explains what you can do in any of the five following situations:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

1. You think we cover medical care you need but are not getting.

**What you can do:** You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

**What you can do:** You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we will not pay.

**What you can do:** You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

**What you can do:** You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

**What you can do:** You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

- If the coverage is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Refer to **Section H** *[insert reference, as applicable]* or **Section I** *[insert reference, as applicable]* to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

## F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **"integrated organization determination."**

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: *<phone number>* TTY: *<phone number>*.
- Faxing: *<phone number>*.
- Writing: *<address>*.

### Standard coverage decision



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

When we give you our decision, we use the “standard” deadlines unless we agree to use the “fast” deadlines. A standard coverage decision means we give you an answer about a:

- Medical service or item within 14 calendar days after we get your request. *[Plan may adjust timeframe if state has more restrictive requirement as directed by the state.]*
- Medicare Part B prescription drug within 72 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can’t take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a “fast complaint” about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, Refer to **Section K** *[insert reference, as applicable]*.

#### Fast coverage decision

The legal term for “fast coverage decision” is “**expedited determination**.”

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a “fast coverage decision.” A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can’t take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a “fast complaint” about our decision to take extra days. For more information about making a complaint, including a fast complaint, Refer to **Section K** *[insert reference, as applicable]*. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- You are asking for coverage for medical care you **did not get**. You can't ask for a fast coverage decision about payment for medical care you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

**We automatically give you a fast coverage decision if your doctor tells us your health requires it.** If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K** *[insert reference, as applicable]*.

**If we say No to part or all of your request**, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3** *[insert reference, as applicable]*).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- If the request is incomplete,
- If someone makes the request on your behalf but isn't legally authorized to do so, or
- If you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

### **F3. Making a Level 1 Appeal**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**To start an appeal**, you, your doctor, or your representative must contact us. Call us at *<phone number> [insert additional contact information, as applicable]*.

**Ask for a standard appeal or a fast appeal** in writing or by calling us at <phone number>.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, *[insert as applicable: you may need to name them as your representative to act on your behalf.]*
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) *[plans may also insert: or on our website at <web address or link to form>]*.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

The legal term for “fast appeal” is “**expedited reconsideration.**”

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- The process for a fast appeal is the same as for a fast coverage decision. To ask for a fast appeal, follow the instructions for asking for a fast coverage decision in **Section F2** *[insert reference, as applicable]*.
- If your doctor tells us that your health requires it, we will give you a fast appeal.

**If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.**

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.
  - If you do not appeal before these dates, then your service or medication will not be continued while you wait for your appeal decision.

**We consider your appeal and give you our answer.**

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

**There are deadlines for a fast appeal.**

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
- If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage if a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In <insert name of state> a Fair Hearing is called <insert description>.]*
- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request**, we send your appeal to the Independent Review Organization for a Level 2 Appeal.

**There are deadlines for a standard appeal.**

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If you think we should **not** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage if a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In <insert name of state> a Fair Hearing is called <insert description>.]*

If we say **Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights**:

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the Independent Review Organization for a Level 2 Appeal.
- If your problem is about coverage of a *[insert name of state-specific Medicaid program]* service or item, the letter tells you how to file a Level 2 Appeal yourself.

#### F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, *[insert name of state-specific Medicaid program]*, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that *[insert name of state-specific Medicaid program]* usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter *[insert reference, as applicable]*.
- If your problem is about a service or item that **both Medicare and** *[insert name of state-specific Medicaid program]* may cover, you automatically get a Level 2 Appeal with the Independent Review Organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** *[insert reference, as applicable]* for information about continuing your benefits during Level 1 Appeals.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the Independent Review Organization.
- If your problem is about a service that usually covered only by [\[insert state-specific name of Medicaid program\]](#), your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

#### **When your problem is about a service or item Medicare usually covers**

The Independent Review Organization reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**," sometimes called the "**IRE**."

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the Independent Review Organization, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization take a careful look at all information related to your appeal.

#### **If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.**

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The Independent Review Organization must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

#### **If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.**

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- 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 getting your appeal.
- If your request is for a Medicare Part B prescription drug, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

The Independent Review Organization gives you their answer in writing and explains the reasons.

- **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 Independent Review Organization's decision for **standard requests or**
  - Provide the service **within 72 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- **If the Independent Review Organization says Yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Medicare Part B prescription drug under dispute:
  - **Within 72 hours** after we get the Independent Review Organization's decision for **standard requests or**
  - **Within 24 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- **If the Independent Review Organization says No to part or all of your appeal**, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- There are three additional levels in the appeals process after Level 2, for a total of five levels.
- If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
- An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** *[insert reference, as applicable]* for more information about Level 3, 4, and 5 Appeals.

**When your problem is about a service or item Medicaid usually covers, or that is covered by both Medicare and *[insert name of state-specific Medicaid program]***

A Level 2 Appeal for services that *[insert name of state-specific Medicaid program]* usually covers is a Fair Hearing with the state. In *<insert name of state>* a Fair Hearing is called *<insert description>*. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

*[Plans should describe the process for Medicaid Level 2 Appeals, in which members must submit the Level 2 Appeal themselves.]*

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the Independent Review Organization or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **Independent Review Organization**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the Independent Review Organization explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Refer to **Section J** *[insert reference, as applicable]* for more information about your appeal rights after Level 2.

## F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. *[Plans with cost sharing insert: The only amount you should be asked to pay is the copay for [insert service, item, and/or drug categories that require a copay].]*

*[Plans insert if the state DOES NOT allow members to be directly reimbursed for Medicaid benefits: We can't reimburse you directly for a Medicaid service or item. If you get a bill [plans with cost sharing insert: that is more than your copay] for Medicaid covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.]*

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to Chapter 7 of your Member Handbook.]

*[Plans insert if the state DOES allow members to be directly reimbursed for Medicaid benefits: If you get a bill [plans with cost sharing insert: that is more than your copay] for covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.]*

*For more information, refer to Chapter 7 of your Member Handbook. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.*

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.]

- If the service or item you paid for is covered and you followed all the rules, we will send *[insert: you or your provider]* *[insert: the payment or if the plan has cost sharing, our share of the cost]* for the service or item within 60 calendar days after we get your request. *[Insert, as applicable: Your provider will then send the payment to you.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3** *[insert reference, as applicable]*. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the Independent Review Organization. We will send you a letter if this happens.

- If the Independent Review Organization reverses our decision and says we should pay you, we must send the payment to you or to the provider 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 to you or to the health care provider within 60 calendar days.
- If the Independent Review Organization says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and *[insert name of Medicaid program]* usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information. *[Plans may edit as needed and/or provide additional instructions about the process for Level 2 payment appeals.]*

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## G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that *[insert name of state-specific Medicaid program]* may cover. **This section only applies to**



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Medicare Part D drug appeals.** We'll say "drug" in the rest of this section. Instead of saying "Medicare Part D drug" every time. *[Insert as applicable and adjust language as directed by the state: For drugs covered only by Medicaid follow the process in Section E on page <insert page number>.]*

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Member Handbook* for more information about a medically accepted indication.

### G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - Cover a Medicare Part D drug that is not on our plan's Drug List or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

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

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

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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 make an appeal. Use the chart below to help you.

| Which of these situations are you in?                                                                             |                                                                                                                                                              |                                                                               |                                                                             |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.     | You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need. | You want to ask us to pay you back for a drug you already got and paid for.   | We told you that we won't cover or pay for a drug in the way that you want. |
| <b>You can ask us to make an exception.</b><br>(This is a type of coverage decision.)                             | <b>You can ask us for a coverage decision.</b>                                                                                                               | <b>You can ask us to pay you back.</b> (This is a type of coverage decision.) | <b>You can make an appeal.</b> (This means you ask us to reconsider.)       |
| Start with <b>Section G2</b> , then refer to <b>Sections G3 and G4</b> <i>[insert reference, as applicable]</i> . | Refer to <b>Section G4</b> <i>[insert reference, as applicable]</i> .                                                                                        | Refer to <b>Section G4</b> <i>[insert reference, as applicable]</i> .         | Refer to <b>Section G5</b> <i>[insert reference, as applicable]</i> .       |

**G2. Medicare Part D exceptions**

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

**1. Covering a drug that is not on our Drug List**

- *[Plans without cost sharing delete]* If we agree to make an exception and cover a drug that is not on our Drug List, you pay the copay that applies *[insert as appropriate: to all of our drugs or drugs in [insert exceptions tier] or drugs in [insert exceptions tier] for brand name drugs or [insert exceptions tier] for generic drugs]*.
- You can't get an exception to the required copay amount for the drug.

## 2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Member Handbook* for more information).
  - Extra rules and restrictions for certain drugs include:
    - *[Omit if the plan does not use generic substitution]* Being required to use the generic version of a drug instead of the brand name drug.
    - *[Omit if the plan does not use prior authorization (PA)]* Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
    - *[Omit if the plan does not use step therapy]* Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
    - *[Omit if the plan does not use quantity limits]* Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
  - *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit this bullet.]* If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.
3. *[Plans with no cost sharing and plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions, omit this section.]* **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of *[insert number of tiers]* cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

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

- Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
  - *[Plans that have a formulary structure where all biological products are on one tier or that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.
  - *[Plans that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
  - *[Plans that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.
- *[If the plan designated one of its tiers as a “specialty tier” and exempts that tier from the exceptions process, include the following language: You can’t ask us to change the cost-sharing tier for any drug in [insert tier number and name of tier designated as the high-cost/unique drug tier].]*
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can’t take, you usually pay the lowest amount.

### G3. Important things to know about asking for an exception

#### Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for 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 often includes more than one drug for treating a specific condition. These are called “alternative” drugs. If an alternative drug is just as effective as the drug you ask for and wouldn’t cause more side effects or other health problems, we generally do **not** approve your exception request. *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit the next sentence.]* If you ask us for a tiering exception, we generally do **not** approve your exception request unless all 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 you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar 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 exception request, you can make an appeal. Refer to **Section G5** *[insert reference, as applicable]* for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

#### G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling <phone number>, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** *[insert reference, as applicable]* to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.
- *[Plans that allow members to submit coverage determination requests electronically (e.g., through a secure member portal) may include a brief description of that process.]*

#### If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

- You can get a fast coverage decision if:
- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K** *[insert reference, as applicable]*.

#### Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization. Refer to **Section G6** *[insert reference, as applicable]* for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

#### Deadlines for a standard coverage decision about 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 send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

### G5. Making a Level 1 Appeal

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

- Start your **standard** or **fast appeal** by calling <phone number>, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your claim.
- You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

had a serious illness or we gave you the wrong information about the deadline.  
Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal.  
You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

A fast appeal is also called an “**expedited redetermination.**”

- If you appeal a decision we made about a drug you didn’t get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** *[insert reference, as applicable]* for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1**

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
- We give you our answer sooner if your health requires it.
  - If we don’t give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** *[insert reference, as applicable]* for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

**Deadlines for a standard appeal at Level 1**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** [\[insert reference, as applicable\]](#) for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** [\[insert reference, as applicable\]](#) for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

## G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **Independent Review Organization** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



The formal name for the “Independent Review Organization” is the “**Independent Review Entity**,” sometimes called the “**IRE**.”

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the Independent Review Organization **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you include **instructions about how to make a Level 2 Appeal** with the Independent Review Organization. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the Independent Review Organization, we send the information we have about your appeal to the organization. This information is called your “case file.” **You have the right to a free copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

The Independent Review Organization reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** *[insert reference, as applicable]* for more information about the Independent Review Organization.

#### **Deadlines for a fast appeal at Level 2**

If your health requires it, ask the Independent Review Organization for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the Independent Review Organization's decision.

#### **Deadlines for a standard appeal at Level 2**

If you have a standard appeal at Level 2, the Independent Review Organization must give you an answer:

- **Within 7 calendar days** after they get your appeal for a drug you didn't get.
- **Within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the Independent Review Organization says **Yes** to part or all of your request:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We must provide the approved drug coverage **within 72 hours** after we get the Independent Review Organization's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the Independent Review Organization's decision.
  - If the Independent Review Organization says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the Independent Review Organization says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The Independent Review Organization sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the Independent Review Organization says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the Independent Review Organization sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Member Handbook*.

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

## H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Call Medicare at 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit [www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices).

## H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In *[insert name of state]*, the Quality Improvement Organization is *[insert state-specific QIO name]*. Call them at *[insert QIO toll-free phone number]*. Contact information is also in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**.

**Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date.**

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the Quality Improvement Organization’s decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, appeal to our plan directly instead. Refer to **Section G4** *[insert reference, as applicable]* for information about making an appeal to us.

**Ask for help if you need it.** If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the *[insert name of state SHIP including contact information]*.

**Ask for a fast review.** Act quickly and contact the Quality Improvement Organization to ask for a fast review of your hospital discharge.

The legal term for “**fast review**” is “**immediate review**” or “**expedited review**.”



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### What happens during fast review

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the “**Detailed Notice of Discharge.**” You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices).

Within one full day after getting all of the information it needs, the Quality Improvement Organization give you their answer to your appeal.

If the Quality Improvement Organizations says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Improvement Organization says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- 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 their answer to your appeal.
- You can make a Level 2 Appeal if the Quality Improvement Organization turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

### H3. Making a Level 2 Appeal



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at [\[insert QIO toll-free phone number\]](#).

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

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Quality Review Organization says **Yes** to your appeal:

- We must pay you back for [\[plans with cost sharing should include: our share of\]](#) hospital care costs since noon on the day after the date the Quality Improvement Organization turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Review Organization says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

#### H4. Making a Level 1 Alternate Appeal

The deadline for contacting the Quality Improvement Organization for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

The legal term for "fast review" or "fast appeal" is "**expedited appeal**."

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any [\[plans with cost sharing should include: share\]](#) of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of giving saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** [\[insert reference, as applicable\]](#) for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- Home health care services
- Skilled nursing care in a skilled nursing facility
- Rehabilitation care as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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.

### I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

### I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** *[insert reference, as applicable]* for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the *[insert state name of SHIP program and contact information]*.
- **Contact the Quality Improvement Organization.**
  - Refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal."** Ask the Quality Improvement Organization if it's medically appropriate for us to end coverage of your medical services.

#### Your deadline for contacting this organization

- 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 we sent you.
- If you miss the deadline for contacting the Quality Improvement Organization, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4** *[insert reference, as applicable]*.

The legal term for the written notice is "**Notice of Medicare Non-Coverage.**" To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or get a copy online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices).

#### What happens during a fast-track appeal



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is “**Detailed Explanation of Non-Coverage.**”

- Reviewers tell you their decision within one full day after getting all the information they need.

If the Independent Review Organization says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying *[plans with cost sharing should include: our share of]* the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

### 13. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at *[insert QIO toll-free phone number]*.

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 continue care after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

#### **I4. Making a Level 1 Alternate Appeal**

As explained in **Section I2** [\[insert reference, as applicable\]](#), you must act quickly and contact the Quality Improvement Organization to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review.”

The legal term for “fast review” or “fast appeal” is “**expedited appeal**.”

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We agree to pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- If we say **No** to your fast appeal:
- Our coverage for these services ends on the date we told you.
- We will not pay any *[plans with cost sharing should include: share]* of the costs after this date.
- You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

## 15. Making a Level 2 Alternate Appeal

During the Level 2 Appeal,

**Commented [BW4]:** Formatting or content may be missing here.

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** *[insert reference, as applicable]* for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

---

## J. Taking your appeal beyond Level 2

### J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the Independent Review Organization for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we 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 service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 reviews your appeal and gives you an answer. The Council is part of the federal government.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

#### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

#### J2. Additional *[insert name of state-specific Medicaid program]* appeals

You also have other appeal rights if your appeal is about services or items that *[insert name of state-specific Medicaid program]* usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

*[Plans may, at the discretion of the state, insert a clear, brief description of the procedures, timing, and instructions about what members need to do if they want to file an additional appeal in the state.]*

**Commented [BW5]:** We will definitely want to have the plans include consistent language here.

#### J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

#### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

---

## K. How to make a complaint

### K1. What kinds of problems should be complaints



---

If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

| Complaint                                                             | Example                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Quality of your medical care</b>                                   | <ul style="list-style-type: none"> <li>You are unhappy with the quality of care, such as the care you got in the hospital.</li> </ul>                                                                                                                                                                                                                                                                        |
| <b>Respecting your privacy</b>                                        | <ul style="list-style-type: none"> <li>You think that someone did not respect your right to privacy or shared confidential information about you.</li> </ul>                                                                                                                                                                                                                                                 |
| <b>Disrespect, poor customer service, or other negative behaviors</b> | <ul style="list-style-type: none"> <li>A health care provider or staff was rude or disrespectful to you.</li> <li>Our staff treated you poorly.</li> <li>You think you are being pushed out of our plan.</li> </ul>                                                                                                                                                                                          |
| <b>Accessibility and language assistance</b>                          | <ul style="list-style-type: none"> <li>You cannot physically access the health care services and facilities in a doctor or provider's office.</li> <li>Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish).</li> <li>Your provider does not give you other reasonable accommodations you need and ask for.</li> </ul> |
| <b>Waiting times</b>                                                  | <ul style="list-style-type: none"> <li>You have trouble getting an appointment or wait too long to get it.</li> <li>Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.</li> </ul>                                                                                                                                                          |
| <b>Cleanliness</b>                                                    | <ul style="list-style-type: none"> <li>You think the clinic, hospital or doctor's office is not clean.</li> </ul>                                                                                                                                                                                                                                                                                            |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.



| Complaint                                           | Example                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Information you get from us                         | <ul style="list-style-type: none"> <li>You think we failed to give you a notice or letter that you should have received.</li> <li>You think written information we sent you is too difficult to understand.</li> </ul>                                                                                                                                                                                                                               |
| Timeliness related to coverage decisions or appeals | <ul style="list-style-type: none"> <li>You think we don't meet our deadlines for making a coverage decision or answering your appeal.</li> <li>You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services.</li> <li>You don't think we sent your case to the Independent Review Organization on time.</li> </ul> |

**There are different kinds of complaints.** You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call [\[insert contacts and contact information\]](#).

The legal term for a “complaint” is a “**grievance.**”

The legal term for “making a complaint” is “**filing a grievance.**”

## K2. Internal complaints

To make an internal complaint, call Member Services at [<phone number>](#). You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *[Insert additional description of the procedures (including time frames) and instructions about what members need to do if they want to use the process for making a complaint, including a fast complaint.]*

**The legal term for “fast complaint” is “expedited grievance.”**

If possible, we 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. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don’t make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don’t agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

### K3. External complaints

#### Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). You do not need to file a complaint with *[insert plan name]* before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

*[Insert additional Medicaid information as required by the state.]*

#### Office for Civil Rights



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

You can make a complaint to the Department of Health and Human Services Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for more information.

You may also contact the local Office for Civil Rights office at:

*[Plans should insert contact information for the OCR regional office.]*

You may also have rights under the Americans with Disability Act and under *[plans may insert relevant state law]*. You can contact *[insert contacts and contact information]*.

### Quality Improvement Organization

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the Quality Improvement Organization.
- You can make your complaint to the Quality Improvement Organization and to our plan. If you make a complaint to the Quality Improvement Organization, we work with them to resolve your complaint.

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. To learn more about the Quality Improvement Organization, refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook*.

In *<state>*, the Quality Improvement Organization is called *<state-specific QIO name>*. The phone number for *<state-specific QIO name>* is *<phone number>*.



**If you have questions**, please call *<plan name>* at *<toll-free phone and TTY numbers>*, *<days and hours of operation>*. The call is free. **For more information**, visit *<web address>*.

*Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.*

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<Plan name> MEMBER HANDBOOK

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

*[Plans that integrate the description of Medicare and Medicaid processes must revise the sections of this chapter as needed to clearly describe the appeals and grievance processes.]*

**Commented [BW1]:** These edits are potentially extensive; how should states communicate these edits with plans to ensure consistency?

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[In cases where members should contact a department other than Member Services (for example, a grievance and appeals unit), plans should revise the instructions to provide the appropriate contact information.]*

### Introduction

This chapter has information about your rights. Read this chapter to find out what to do if: *[Add any additional language for state-specific Medicaid information]*

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

*[Plans must include information about the ombudsman program, if directed by the state.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

**Commented [BW2]:** Our state has always had a paragraph here referring people to our ombudsman as a resource for appeals. Assuming they remain in that role for 2024, should we add an instruction here or is this addressed adequately elsewhere?

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints**; also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

### A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” instead of “Independent Review Entity”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

---

## B. Where to get help

### B1. For more information and help

Sometimes it's confusing to start or follow the process for dealing with a problem. This can be especially true if you don't feel well or have limited energy. Other times, you may not have the information you need to take the next step.

**Help from the** *[Insert state-specific name of the SHIP program]*

You can call the *[insert state-specific name of the SHIP program]*. *[insert state-specific name of the SHIP program]* counselors can answer your questions and help you understand what to do about your problem. *[Insert state-specific name of the SHIP program]* is not connected with us or with any insurance company or health plan. *[Insert state-specific name of the SHIP program]* has trained counselors in every county, and services are free. The *[insert state-specific name of the SHIP program]* phone number is *[insert phone number]*.



---

**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)).

### Help and information from *[insert name of state-specific Medicaid program]*

*[Insert contact information for the state Medicaid agency. Insert similar sections for the QIO or ombudsman, as applicable.]*

**Commented [BW3]:** Thank you; they are existing resources for our members.

---

## C. Understanding Medicare and *[insert name of state-specific Medicaid program]* complaints and appeals in our plan

You have Medicare and *[insert name of state-specific Medicaid program]*. Information in this chapter applies to **all** of your Medicare and *[insert name of state-specific Medicaid program]* benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and *[insert state-specific name of Medicaid program]* processes.

Sometimes Medicare and *[insert state-specific name of Medicaid program]* processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a *[insert state-specific name of Medicaid program]* benefit. **Section F4** explains these situations.

---

## D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The chart below helps you find the right section of this chapter for problems or complaints.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



|                                                                                                                                                                                                                                                                               |                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <b>Is your problem or concern about your benefits or coverage?</b><br><br>This includes problems about whether particular medical care or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs. |                                                                                                                                 |
| <b>Yes.</b><br>My problem is about<br>benefits or coverage.<br><br>Refer to <b>Section E</b> , "Coverage decisions<br>and appeals."                                                                                                                                           | <b>No.</b><br>My problem is not about<br>benefits or coverage.<br><br>Refer to <b>Section K</b> , "How to make a<br>complaint." |

## E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

### E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. We make a coverage decision whenever we decide what is covered for you and how much we pay. For example, your network doctor makes a favorable coverage decision for you whenever you get medical care from them or if they refer you to a medical specialist.

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or [\[insert state-specific name of Medicaid program\]](#). If you disagree with this coverage decision, you can make an appeal.

### E2. Appeals

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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 if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter *[insert reference, as applicable]*, you can ask for an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare medical service or item or Part B drugs, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

### E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- *[Insert name of SHIP program and contact information.]*
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

*[Insert any additional state-specific references for assistance with coverage decisions and appeals as applicable.]*

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the “Appointment of Representative” form. You can also get the form by visiting [www.cms.gov/Medicare/CMS-](http://www.cms.gov/Medicare/CMS-)



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

[Forms/CMS-Forms/downloads/cms1696.pdf](#) *[plans may also insert: or on our website at <web address or link to form>]. You must give us a copy of the signed form.*

#### E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, “Medical care” *[insert reference, as applicable]*
- **Section G**, “Medicare Part D prescription drugs” *[insert reference, as applicable]*
- **Section H**, “Asking us to cover a longer hospital stay” *[insert reference, as applicable]*
- **Section I**, “Asking us to continue covering certain medical services” *[insert reference, as applicable]* (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you’re not sure which section to use, call Member Services at the numbers at the bottom of the page. *[Plans may insert additional resources and contact information (e.g., SHIP, Ombudsman Program).]*

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### F. Medical care

*[Plans may update the heading and terms such as “medical care” throughout to account for Medicaid services such as behavioral health and long-term care services as directed by the state.]*

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for *[insert if plan has cost sharing: our share of the cost of]* your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of your *Member Handbook*. We generally refer to “medical care coverage” or “medical care” in the rest of this section. The term “medical care” includes medical services and items as well as Medicare Part B prescription drugs which are drugs administered by your doctor or health care professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

#### F1. Using this section

This section explains what you can do in any of the five following situations:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

1. You think we cover medical care you need but are not getting.

**What you can do:** You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

**What you can do:** You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we will not pay.

**What you can do:** You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

**What you can do:** You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

**What you can do:** You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

- If the coverage is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Refer to **Section H** *[insert reference, as applicable]* or **Section I** *[insert reference, as applicable]* to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

## F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **"integrated organization determination."**

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: *<phone number>* TTY: *<phone number>*.
- Faxing: *<phone number>*.
- Writing: *<address>*.

### Standard coverage decision



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

When we give you our decision, we use the “standard” deadlines unless we agree to use the “fast” deadlines. A standard coverage decision means we give you an answer about a:

- Medical service or item within 14 calendar days after we get your request. *[Plan may adjust timeframe if state has more restrictive requirement as directed by the state.]*
- Medicare Part B prescription drug within 72 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can’t take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a “fast complaint” about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, Refer to **Section K** *[insert reference, as applicable]*.

#### Fast coverage decision

The legal term for “fast coverage decision” is “**expedited determination**.”

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a “fast coverage decision.” A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can’t take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a “fast complaint” about our decision to take extra days. For more information about making a complaint, including a fast complaint, Refer to **Section K** *[insert reference, as applicable]*. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- You are asking for coverage for medical care you **did not get**. You can't ask for a fast coverage decision about payment for medical care you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

**We automatically give you a fast coverage decision if your doctor tells us your health requires it.** If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K** *[insert reference, as applicable]*.

**If we say No to part or all of your request**, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3** *[insert reference, as applicable]*).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- If the request is incomplete,
- If someone makes the request on your behalf but isn't legally authorized to do so, or
- If you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

### **F3. Making a Level 1 Appeal**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**To start an appeal**, you, your doctor, or your representative must contact us. Call us at *<phone number> [insert additional contact information, as applicable]*.

**Ask for a standard appeal or a fast appeal** in writing or by calling us at <phone number>.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, *[insert as applicable: you may need to name them as your representative to act on your behalf.]*
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) *[plans may also insert: or on our website at <web address or link to form>]*.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

The legal term for “fast appeal” is “**expedited reconsideration.**”

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- The process for a fast appeal is the same as for a fast coverage decision. To ask for a fast appeal, follow the instructions for asking for a fast coverage decision in **Section F2** *[insert reference, as applicable]*.
- If your doctor tells us that your health requires it, we will give you a fast appeal.

**If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.**

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.
  - If you do not appeal before these dates, then your service or medication will not be continued while you wait for your appeal decision.

**We consider your appeal and give you our answer.**

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

**There are deadlines for a fast appeal.**

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
- If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage if a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In <insert name of state> a Fair Hearing is called <insert description>.]*
- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request**, we send your appeal to the Independent Review Organization for a Level 2 Appeal.

**There are deadlines for a standard appeal.**

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If you think we should **not** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage if a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In <insert name of state> a Fair Hearing is called <insert description>.]*

If we say **Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights**:

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the Independent Review Organization for a Level 2 Appeal.
- If your problem is about coverage of a *[insert name of state-specific Medicaid program]* service or item, the letter tells you how to file a Level 2 Appeal yourself.

#### F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, *[insert name of state-specific Medicaid program]*, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that *[insert name of state-specific Medicaid program]* usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter *[insert reference, as applicable]*.
- If your problem is about a service or item that **both Medicare and** *[insert name of state-specific Medicaid program]* may cover, you automatically get a Level 2 Appeal with the Independent Review Organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** *[insert reference, as applicable]* for information about continuing your benefits during Level 1 Appeals.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the Independent Review Organization.
- If your problem is about a service that usually covered only by [\[insert state-specific name of Medicaid program\]](#), your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

#### **When your problem is about a service or item Medicare usually covers**

The Independent Review Organization reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**," sometimes called the "**IRE**."

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the Independent Review Organization, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization take a careful look at all information related to your appeal.

#### **If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.**

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The Independent Review Organization must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

#### **If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.**

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- 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 getting your appeal.
- If your request is for a Medicare Part B prescription drug, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

The Independent Review Organization gives you their answer in writing and explains the reasons.

- **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 Independent Review Organization's decision for **standard requests or**
  - Provide the service **within 72 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- **If the Independent Review Organization says Yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Medicare Part B prescription drug under dispute:
  - **Within 72 hours** after we get the Independent Review Organization's decision for **standard requests or**
  - **Within 24 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- **If the Independent Review Organization says No to part or all of your appeal**, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- There are three additional levels in the appeals process after Level 2, for a total of five levels.
- If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
- An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** *[insert reference, as applicable]* for more information about Level 3, 4, and 5 Appeals.

**When your problem is about a service or item Medicaid usually covers, or that is covered by both Medicare and *[insert name of state-specific Medicaid program]***

A Level 2 Appeal for services that *[insert name of state-specific Medicaid program]* usually covers is a Fair Hearing with the state. In *<insert name of state>* a Fair Hearing is called *<insert description>*. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

*[Plans should describe the process for Medicaid Level 2 Appeals, in which members must submit the Level 2 Appeal themselves.]*

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the Independent Review Organization or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **Independent Review Organization**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the Independent Review Organization explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Refer to **Section J** *[insert reference, as applicable]* for more information about your appeal rights after Level 2.

## F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. *[Plans with cost sharing insert: The only amount you should be asked to pay is the copay for [insert service, item, and/or drug categories that require a copay].]*

*[Plans insert if the state DOES NOT allow members to be directly reimbursed for Medicaid benefits: We can't reimburse you directly for a Medicaid service or item. If you get a bill [plans with cost sharing insert: that is more than your copay] for Medicaid covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.]*

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to Chapter 7 of your Member Handbook.]

*[Plans insert if the state DOES allow members to be directly reimbursed for Medicaid benefits: If you get a bill [plans with cost sharing insert: that is more than your copay] for covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.]*

*For more information, refer to Chapter 7 of your Member Handbook. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.*

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.]

- If the service or item you paid for is covered and you followed all the rules, we will send *[insert: you or your provider]* *[insert: the payment or if the plan has cost sharing, our share of the cost]* for the service or item within 60 calendar days after we get your request. *[Insert, as applicable: Your provider will then send the payment to you.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3** *[insert reference, as applicable]*. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the Independent Review Organization. We will send you a letter if this happens.

- If the Independent Review Organization reverses our decision and says we should pay you, we must send the payment to you or to the provider 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 to you or to the health care provider within 60 calendar days.
- If the Independent Review Organization says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and *[insert name of Medicaid program]* usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information. *[Plans may edit as needed and/or provide additional instructions about the process for Level 2 payment appeals.]*

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## G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that *[insert name of state-specific Medicaid program]* may cover. **This section only applies to**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Medicare Part D drug appeals.** We'll say "drug" in the rest of this section. Instead of saying "Medicare Part D drug" every time. *[Insert as applicable and adjust language as directed by the state: For drugs covered only by Medicaid follow the process in Section E on page <insert page number>.]*

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Member Handbook* for more information about a medically accepted indication.

### G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - Cover a Medicare Part D drug that is not on our plan's Drug List or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

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

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

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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 make an appeal. Use the chart below to help you.

| Which of these situations are you in?                                                                             |                                                                                                                                                              |                                                                               |                                                                             |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.     | You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need. | You want to ask us to pay you back for a drug you already got and paid for.   | We told you that we won't cover or pay for a drug in the way that you want. |
| <b>You can ask us to make an exception.</b><br>(This is a type of coverage decision.)                             | <b>You can ask us for a coverage decision.</b>                                                                                                               | <b>You can ask us to pay you back.</b> (This is a type of coverage decision.) | <b>You can make an appeal.</b> (This means you ask us to reconsider.)       |
| Start with <b>Section G2</b> , then refer to <b>Sections G3 and G4</b> <i>[insert reference, as applicable]</i> . | Refer to <b>Section G4</b> <i>[insert reference, as applicable]</i> .                                                                                        | Refer to <b>Section G4</b> <i>[insert reference, as applicable]</i> .         | Refer to <b>Section G5</b> <i>[insert reference, as applicable]</i> .       |

**G2. Medicare Part D exceptions**

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

**1. Covering a drug that is not on our Drug List**

- *[Plans without cost sharing delete]* If we agree to make an exception and cover a drug that is not on our Drug List, you pay the copay that applies *[insert as appropriate: to all of our drugs or drugs in [insert exceptions tier] or drugs in [insert exceptions tier] for brand name drugs or [insert exceptions tier] for generic drugs]*.
- You can't get an exception to the required copay amount for the drug.

## 2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Member Handbook* for more information).
  - Extra rules and restrictions for certain drugs include:
    - *[Omit if the plan does not use generic substitution]* Being required to use the generic version of a drug instead of the brand name drug.
    - *[Omit if the plan does not use prior authorization (PA)]* Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
    - *[Omit if the plan does not use step therapy]* Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
    - *[Omit if the plan does not use quantity limits]* Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
  - *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit this bullet.]* If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.
3. *[Plans with no cost sharing and plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions, omit this section.]* **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of *[insert number of tiers]* cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

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

- Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
  - *[Plans that have a formulary structure where all biological products are on one tier or that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.
  - *[Plans that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
  - *[Plans that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.
- *[If the plan designated one of its tiers as a “specialty tier” and exempts that tier from the exceptions process, include the following language: You can’t ask us to change the cost-sharing tier for any drug in [insert tier number and name of tier designated as the high-cost/unique drug tier].]*
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can’t take, you usually pay the lowest amount.

### G3. Important things to know about asking for an exception

#### Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for 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 often includes more than one drug for treating a specific condition. These are called “alternative” drugs. If an alternative drug is just as effective as the drug you ask for and wouldn’t cause more side effects or other health problems, we generally do **not** approve your exception request. *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit the next sentence.]* If you ask us for a tiering exception, we generally do **not** approve your exception request unless all 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 you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar 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 exception request, you can make an appeal. Refer to **Section G5** *[insert reference, as applicable]* for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

#### **G4. Asking for a coverage decision, including an exception**

- Ask for the type of coverage decision you want by calling <phone number>, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** *[insert reference, as applicable]* to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.
- *[Plans that allow members to submit coverage determination requests electronically (e.g., through a secure member portal) may include a brief description of that process.]*

#### **If your health requires it, ask us for a "fast coverage decision."**

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

- You can get a fast coverage decision if:
- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K** *[insert reference, as applicable]*.

#### Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization. Refer to **Section G6** *[insert reference, as applicable]* for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

#### Deadlines for a standard coverage decision about 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 send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

### G5. Making a Level 1 Appeal

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

- Start your **standard** or **fast appeal** by calling <phone number>, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your claim.
- You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

had a serious illness or we gave you the wrong information about the deadline.  
Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

A fast appeal is also called an “**expedited redetermination.**”

- If you appeal a decision we made about a drug you didn’t get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** *[insert reference, as applicable]* for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1**

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
- We give you our answer sooner if your health requires it.
  - If we don’t give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** *[insert reference, as applicable]* for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

**Deadlines for a standard appeal at Level 1**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** [\[insert reference, as applicable\]](#) for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** [\[insert reference, as applicable\]](#) for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

## G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **Independent Review Organization** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



The formal name for the “Independent Review Organization” is the “**Independent Review Entity**,” sometimes called the “**IRE**.”

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the Independent Review Organization **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you include **instructions about how to make a Level 2 Appeal** with the Independent Review Organization. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the Independent Review Organization, we send the information we have about your appeal to the organization. This information is called your “case file.” **You have the right to a free copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

The Independent Review Organization reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** *[insert reference, as applicable]* for more information about the Independent Review Organization.

#### **Deadlines for a fast appeal at Level 2**

If your health requires it, ask the Independent Review Organization for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the Independent Review Organization's decision.

#### **Deadlines for a standard appeal at Level 2**

If you have a standard appeal at Level 2, the Independent Review Organization must give you an answer:

- **Within 7 calendar days** after they get your appeal for a drug you didn't get.
- **Within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the Independent Review Organization says **Yes** to part or all of your request:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We must provide the approved drug coverage **within 72 hours** after we get the Independent Review Organization's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the Independent Review Organization's decision.
  - If the Independent Review Organization says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the Independent Review Organization says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The Independent Review Organization sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the Independent Review Organization says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the Independent Review Organization sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Member Handbook*.

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

## H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Call Medicare at 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit [www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices).

## H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In *[insert name of state]*, the Quality Improvement Organization is *[insert state-specific QIO name]*. Call them at *[insert QIO toll-free phone number]*. Contact information is also in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**.

**Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date.**

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the Quality Improvement Organization’s decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, appeal to our plan directly instead. Refer to **Section G4** *[insert reference, as applicable]* for information about making an appeal to us.

**Ask for help if you need it.** If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the *[insert name of state SHIP including contact information]*.

**Ask for a fast review.** Act quickly and contact the Quality Improvement Organization to ask for a fast review of your hospital discharge.

The legal term for “**fast review**” is “**immediate review**” or “**expedited review**.”



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### What happens during fast review

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the “**Detailed Notice of Discharge.**” You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices).

Within one full day after getting all of the information it needs, the Quality Improvement Organization give you their answer to your appeal.

If the Quality Improvement Organizations says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Improvement Organization says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- 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 their answer to your appeal.
- You can make a Level 2 Appeal if the Quality Improvement Organization turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

### H3. Making a Level 2 Appeal



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at [\[insert QIO toll-free phone number\]](#).

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

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Quality Review Organization says **Yes** to your appeal:

- We must pay you back for [\[plans with cost sharing should include: our share of\]](#) hospital care costs since noon on the day after the date the Quality Improvement Organization turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Review Organization says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

#### H4. Making a Level 1 Alternate Appeal

The deadline for contacting the Quality Improvement Organization for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

The legal term for "fast review" or "fast appeal" is "**expedited appeal**."

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any [\[plans with cost sharing should include: share\]](#) of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of giving saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** [\[insert reference, as applicable\]](#) for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- Home health care services
- Skilled nursing care in a skilled nursing facility
- Rehabilitation care as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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.

### I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

### I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** *[insert reference, as applicable]* for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the *[insert state name of SHIP program and contact information]*.
- **Contact the Quality Improvement Organization.**
  - Refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal."** Ask the Quality Improvement Organization if it's medically appropriate for us to end coverage of your medical services.

#### Your deadline for contacting this organization

- 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 we sent you.
- If you miss the deadline for contacting the Quality Improvement Organization, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4** *[insert reference, as applicable]*.

The legal term for the written notice is "**Notice of Medicare Non-Coverage.**" To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or get a copy online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices).

#### What happens during a fast-track appeal



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is “**Detailed Explanation of Non-Coverage.**”

- Reviewers tell you their decision within one full day after getting all the information they need.

If the Independent Review Organization says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying *[plans with cost sharing should include: our share of]* the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

### **I3. Making a Level 2 Appeal**

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at *[insert QIO toll-free phone number]*.

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 continue care after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

#### **I4. Making a Level 1 Alternate Appeal**

As explained in **Section I2** [\[insert reference, as applicable\]](#), you must act quickly and contact the Quality Improvement Organization to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review.”

The legal term for “fast review” or “fast appeal” is “**expedited appeal**.”

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We agree to pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- If we say **No** to your fast appeal:
- Our coverage for these services ends on the date we told you.
- We will not pay any *[plans with cost sharing should include: share]* of the costs after this date.
- You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### 15. Making a Level 2 Alternate Appeal

During the Level 2 Appeal,

**Commented [BW4]:** Formatting or content may be missing here.

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** *[insert reference, as applicable]* for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## J. Taking your appeal beyond Level 2

### J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the Independent Review Organization for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we 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 service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 reviews your appeal and gives you an answer. The Council is part of the federal government.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

#### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

#### J2. Additional *[insert name of state-specific Medicaid program]* appeals

You also have other appeal rights if your appeal is about services or items that *[insert name of state-specific Medicaid program]* usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

*[Plans may, at the discretion of the state, insert a clear, brief description of the procedures, timing, and instructions about what members need to do if they want to file an additional appeal in the state.]*

**Commented [BW5]:** We will definitely want to have the plans include consistent language here.

#### J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

#### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

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## K. How to make a complaint

### K1. What kinds of problems should be complaints



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If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

| Complaint                                                             | Example                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Quality of your medical care</b>                                   | <ul style="list-style-type: none"> <li>You are unhappy with the quality of care, such as the care you got in the hospital.</li> </ul>                                                                                                                                                                                                                                                                        |
| <b>Respecting your privacy</b>                                        | <ul style="list-style-type: none"> <li>You think that someone did not respect your right to privacy or shared confidential information about you.</li> </ul>                                                                                                                                                                                                                                                 |
| <b>Disrespect, poor customer service, or other negative behaviors</b> | <ul style="list-style-type: none"> <li>A health care provider or staff was rude or disrespectful to you.</li> <li>Our staff treated you poorly.</li> <li>You think you are being pushed out of our plan.</li> </ul>                                                                                                                                                                                          |
| <b>Accessibility and language assistance</b>                          | <ul style="list-style-type: none"> <li>You cannot physically access the health care services and facilities in a doctor or provider's office.</li> <li>Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish).</li> <li>Your provider does not give you other reasonable accommodations you need and ask for.</li> </ul> |
| <b>Waiting times</b>                                                  | <ul style="list-style-type: none"> <li>You have trouble getting an appointment or wait too long to get it.</li> <li>Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.</li> </ul>                                                                                                                                                          |
| <b>Cleanliness</b>                                                    | <ul style="list-style-type: none"> <li>You think the clinic, hospital or doctor's office is not clean.</li> </ul>                                                                                                                                                                                                                                                                                            |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.



| Complaint                                           | Example                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Information you get from us                         | <ul style="list-style-type: none"> <li>You think we failed to give you a notice or letter that you should have received.</li> <li>You think written information we sent you is too difficult to understand.</li> </ul>                                                                                                                                                                                                                               |
| Timeliness related to coverage decisions or appeals | <ul style="list-style-type: none"> <li>You think we don't meet our deadlines for making a coverage decision or answering your appeal.</li> <li>You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services.</li> <li>You don't think we sent your case to the Independent Review Organization on time.</li> </ul> |

**There are different kinds of complaints.** You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call [\[insert contacts and contact information\]](#).

The legal term for a “complaint” is a “**grievance.**”

The legal term for “making a complaint” is “**filing a grievance.**”

## K2. Internal complaints

To make an internal complaint, call Member Services at [<phone number>](#). You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *[Insert additional description of the procedures (including time frames) and instructions about what members need to do if they want to use the process for making a complaint, including a fast complaint.]*

**The legal term for “fast complaint” is “expedited grievance.”**

If possible, we 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. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don’t make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don’t agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

### K3. External complaints

#### Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). You do not need to file a complaint with *[insert plan name]* before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

*[Insert additional Medicaid information as required by the state.]*

#### Office for Civil Rights



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

You can make a complaint to the Department of Health and Human Services Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for more information.

You may also contact the local Office for Civil Rights office at:

*[Plans should insert contact information for the OCR regional office.]*

You may also have rights under the Americans with Disability Act and under *[plans may insert relevant state law]*. You can contact *[insert contacts and contact information]*.

### Quality Improvement Organization

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the Quality Improvement Organization.
- You can make your complaint to the Quality Improvement Organization and to our plan. If you make a complaint to the Quality Improvement Organization, we work with them to resolve your complaint.

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. To learn more about the Quality Improvement Organization, refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook*.

In *<state>*, the Quality Improvement Organization is called *<state-specific QIO name>*. The phone number for *<state-specific QIO name>* is *<phone number>*.



**If you have questions**, please call *<plan name>* at *<toll-free phone and TTY numbers>*, *<days and hours of operation>*. The call is free. **For more information**, visit *<web address>*.

*Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.*

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<Plan name> MEMBER HANDBOOK

## Chapter 10: Ending your membership in our plan

### Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and *[Insert state-specific name of Medicaid program]* programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should edit this chapter as directed by the state to reflect Medicaid benefits such as if the plan can continue to provide Medicaid coverage when the member disenrolls from the Medicare plan or if the member is required to belong to a health plan to receive Medicaid benefits, etc..]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction *[insert reference, as applicable]* appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have *[Insert state-specific name of Medicaid program]*, you may be able to end your membership with our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You move out of our service area,
- Your eligibility for *[Insert state-specific name of Medicaid program]* or Extra Help changed, **or**
- If you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1** *[insert reference, as applicable]*.
- Medicaid services in **Section C2** *[insert reference, as applicable]*.

You can get more information about how you can end your membership by calling: *[Insert any additional contact information as required by the state.]*

**Commented [BW1]:** We note that our current demonstration uses a continuous SEP, and members may change plans at any time. This program may be the only one in our state that eventually limits enrollment in this manner. Moving to this model rather than the "continuous Special Enrollment Period for dual eligible members (duals SEP)" will require extensive reprogramming and testing, as well as member and provider communication. We believe it is feasible, but it will be a big lift.

**Commented [BW2]:** At present, we have some passive enrollment into our demonstration. Would passively enrolled members have the same SEPs described above or do we need to modify instructions at all?

**Commented [BW3]:** We will add our enrollment broker here; how should we communicate changes like this to the plans?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP), *<State-specific SHIP name>* at *<phone number>*. *[TTY phone number is optional.]*

**NOTE:** If you're in a drug management program, you may not be able to change plans. Refer to **Chapter 5** of your *Member Handbook* for information about drug management programs.

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## B. How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page <page number>.
- *[Insert if applicable: Call [insert name of state specific Medicaid program and contact information including TTY number]. Section C below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.]*

---

## C. How to get Medicare and *[Insert state-specific name of Medicaid program]* services separately

*[Update this section as needed to include appropriate Medicaid information.]* You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

### C1. Your Medicare services

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership in our plan.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>1. You can change to:</b></p> <p><b>Another Medicare health plan</b></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p><i>[Insert if applicable: For PACE inquiries, call 1-855-921-PACE (7223).]</i></p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call the <i>[insert name of SHIP program]</i> at &lt;phone number&gt;. <i>[TTY phone number is optional.] [Insert as applicable: In &lt;state&gt;, the SHIP is called &lt;name of SHIP&gt;.]</i></li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare plan.</p> <p>You are automatically disenrolled from our Medicare plan when your new plan's coverage begins.</p> <p><i>[Insert any additional information regarding the impact of Medicaid enrollment as directed by the state.]</i></p> |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



|                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>2. You can change to:</b><br><br><b>Original Medicare with a separate Medicare prescription drug plan</b> | <b>Here is what to do:</b><br><br>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.<br><br>If you need help or more information: <ul style="list-style-type: none"><li>• Call the <i>[insert name of SHIP program]</i> at &lt;phone number&gt;. <i>[TTY phone number is optional.] [Insert as applicable: In &lt;state&gt;, the SHIP is called &lt;name of SHIP&gt;.]</i></li></ul><br><b>OR</b><br><br>Enroll in a new Medicare prescription drug plan.<br><br>You are automatically disenrolled from our plan when your Original Medicare coverage begins.<br><br><i>[Insert any additional information regarding the impact of Medicaid enrollment as directed by the state.]</i> |
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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| <p><b>3. You can change to:</b></p> <p><b>Original Medicare without a separate Medicare prescription drug plan</b></p> <p><b>NOTE:</b> If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join.</p> <p>You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the <i>[insert name of state SHIP program]</i> at <i>[insert phone number]</i>, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local <i>[insert name of SHIP office]</i> office in your area, please visit <i>[insert web URL]</i>.</p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call the <i>[insert name of SHIP program]</i> at <i>[phone number]</i>. <i>[TTY phone number is optional.] [Insert as applicable: In &lt;state&gt;, the SHIP is called &lt;name of SHIP&gt;.]</i></li></ul> <p>You are automatically disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert any additional information regarding the impact of Medicaid enrollment as directed by the state.]</i></p> |
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**C2. Your *[Insert state-specific name of Medicaid program]* services**

*[Insert instructions specific to state Medicaid program as directed by the state.]*

**D. Your medical services and drugs until your membership in our plan ends**

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies *[insert if applicable: including through our mail-order pharmacy services]* to get your prescriptions filled.
- If you are hospitalized on the day that your membership in <plan name> ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- *[Plans must insert rules for members who no longer meet special eligibility requirements.]*
- If you move out of our service area.
- If you are away from our service area for more than six months. *[Plans with visitor/traveler benefits should revise this bullet to indicate when the plan must disenroll members.]*
  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
  - *[Plans with visitor/traveler benefits, insert: Refer to **Chapter 4** of your Member Handbook for information on getting care through our visitor or traveler benefits when you're away from our plan's service area.]*
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

*[Insert deemed continuous eligibility information here, if applicable.]*

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your plan ID card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

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## F. Rules against asking you to leave our plan for any health-related reason

We cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

---

## G. Your 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. You can also refer to **Chapter 9** of your *Member Handbook* for information about how to make a complaint.

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## H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.*

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<Plan name> MEMBER HANDBOOK

## Chapter 11: Legal notices

**Commented [BW1]:** Our state had no comments about this chapter.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

### Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans may include other legal notices, such as a notice of member non-liability or a notice about third-party liability, if they conform to Medicare and Medicaid laws and regulations.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

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| C. Notice about Medicare as a second payer and <i>[Insert state-specific name of Medicaid program]</i> as a payer of last resort ..... | 2 |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in the *Member Handbook*. The main laws that apply are federal laws about the Medicare and *[insert name of state-specific Medicaid program]* programs. Other federal and state laws may apply too.

---

## B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. *[Plans may add language describing additional categories covered under state human rights laws as well as the appropriate contact information below.]*

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 users can call 1-800-537-7697. You can also visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for more information.
- Call your local Office for Civil Rights. *[Plans insert contact information for the local office.]*
- If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

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## C. Notice about Medicare as a second payer and *[Insert state-specific name of Medicaid program]* as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that *[insert name of state-specific Medicaid program]* is the payer of last resort.

*[Plans may also include Medicaid-related legal notices.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.*

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<Plan name> MEMBER HANDBOOK

## Chapter 12: Definitions of important words

### Introduction

This chapter includes key terms used throughout your *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans should insert additional definitions not included in this model and exclude model definitions not applicable to your plan, your contractual obligations with CMS or enrolled beneficiaries. Plans should modify definitions as appropriate in the state and/or as directed by the state.]*

*[When plans use key terms in the Member Handbook, they explain the term in the first section where it appears along with a reference to Chapter 12.]*

*[If plans revise terminology (e.g., "Member Services" to "Customer Service," "Care Coordinator" to "Care Manager") that affect glossary terms, plans use the revised term consistently throughout the Member Handbook and alphabetize it in this chapter.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Activities of daily living (ADL):** The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

**Aid paid pending:** You can continue getting your benefits while you are waiting for a decision about a Level 1 Appeal or a State Hearing (Refer to **Chapter 9** of your *Member Handbook* for more information). This continued coverage is called “aid paid pending.”

**Ambulatory surgical center:** A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

**Appeal:** A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your *Member Handbook* explains appeals, including how to make an appeal.

**Behavioral Health:** An all-inclusive term referring to mental health and substance use disorders.

**Brand name drug:** A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

**Care coordinator:** One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

**Care plan:** Refer to “Individualized Care Plan.”

**Care team:** Refer to “Interdisciplinary Care Team.”

*[Plans with a single coverage stage should delete this paragraph.]* **Catastrophic coverage stage:** The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you reach the \$<TrOOP amount> limit for your prescription drugs.

**Centers for Medicare & Medicaid Services (CMS):** The federal agency in charge of Medicare. **Chapter 2** of your *Member Handbook* explains how to contact CMS.

**Complaint:** A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

**Comprehensive outpatient rehabilitation facility (CORF):** A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



*[Plans that do not have copays should delete this paragraph.]* **Copay:** A fixed amount you pay as your share of the cost each time you get certain *[insert if applicable: services or]* prescription drugs. For example, you might pay \$2 or \$5 for *[insert if applicable: a service or]* a prescription drug.

*[Plans that do not have cost sharing should delete this paragraph.]* **Cost sharing:** Amounts you have to pay when you get certain *[insert if applicable: services or]* prescription drugs. Cost sharing includes copays.

*[Plans that do not have cost sharing should delete this paragraph.]* **Cost sharing tier:** A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List) is in one of *[insert number of tiers]* cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

**Coverage decision:** A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your *Member Handbook* explains how to ask us for a coverage decision.

**Covered drugs:** The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

**Covered services:** The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

**Cultural competence training:** Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

*[Plans that do not have cost sharing for Medicare Part D drugs should delete this paragraph. Plans may revise the information in this definition to reflect the appropriate number of days for their one-month supplies as well as the cost-sharing amount in the example.]* **Daily cost sharing rate:** A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost sharing rate is the copay divided by the number of days in a month's supply.

Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment is less than \$0.05 per day multiplied by 7 days, for a total payment less than \$0.35.

**Disenrollment:** The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans that do not have cost sharing add this paragraph.]* **Drug tiers:** Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of *[insert number of tiers]* tiers.

**Dual eligible special needs plan (D-SNP):** Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

**Durable medical equipment (DME):** Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

**Emergency:** A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function *[insert as applicable: (and if you are a pregnant woman, loss of an unborn child)]*. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

**Emergency care:** Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

**Exception:** Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

**Excluded Services:** Services that are not covered by this health plan.

**Extra Help:** Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

**Generic drug:** A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It’s usually cheaper and works just as well as the brand name drug.

**Grievance:** A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

**Health plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

**Health risk assessment:** A review of your medical history and current condition. It’s used to learn about your health and how it might change in the future.

**Commented [BW1]:** We note that the comprehensive assessment was removed from the 2024 models; we assume the HRA described here will play a similar role in the program going forward.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

**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 (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

**Hospice:** A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

**Improper/inappropriate billing:** A situation when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. Call Member Services if you get any bills you don't understand.

*[Plans with cost sharing, insert: As a plan member, you only pay our plan's cost sharing amounts when you get services we cover. We do **not** allow providers to bill you more than this amount.]*

*[Plans with no cost sharing, insert: Because we pay the entire cost for your services, you do **not** owe any cost sharing. Providers should not bill you anything for these services.]*

**Individualized Care Plan (ICP or Care Plan):** A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

*[Plans with a single coverage stage delete this paragraph.]* **Initial coverage stage:** The stage before your total Medicare Part D drug expenses reach \$*[insert initial coverage limit]*. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

**Inpatient:** A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

**Interdisciplinary Care Team (ICT or Care team):** A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**List of Covered Drugs (Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary.”

**Long-term services and supports (LTSS):** Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don’t have to go to a nursing facility or hospital. LTSS include Community Based Services and Nursing Facilities (NF).

**Low-income subsidy (LIS):** Refer to “Extra Help.”

**[Insert name of Medicaid program]:** This is the name of [insert name of state] Medicaid program. [Insert name of Medicaid program] is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medicaid (or Medical Assistance):** A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

**Medically necessary:** This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise and use the state-specific definition of “medically necessary” and update and use it consistently throughout member materials.]*

**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). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

**Medicare Advantage:** A Medicare program, also known as “Medicare Part C” or “MA,” that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

**Medicare-covered services:** Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part B.

**Commented [BW2]:** Formatting note: be sure this is bold.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Medicare-Medicaid enrollee:** A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual.”

**Medicare Part A:** The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

**Medicare Part B:** The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

**Medicare Part C:** The Medicare program, also known as “Medicare Advantage” or “MA,” that lets private health insurance companies provide Medicare benefits through an MA Plan.

**Medicare Part D:** The Medicare prescription drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

**Medicare Part D drugs:** Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

**Medication Therapy Management:** A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your *Member Handbook* for more information.

**Member (member of our plan, or plan member):** A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

**Member Handbook and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

**Member Services:** A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Member Handbook* for more information about Member Services.

**Network pharmacy:** A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Network provider:** “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

**Nursing home or facility:** A place that provides care for people who can’t get their care at home but don’t need to be in the hospital.

**Ombudsman:** An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. You can find more information in **Chapters 2 and 9** of your *Member Handbook*.

**Organization determination:** Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions.” **Chapter 9** of your *Member Handbook* explains coverage decisions.

**Original Medicare (traditional Medicare or fee-for-service Medicare):** The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don’t want to be in our plan, you can choose Original Medicare.

**Out-of-network pharmacy:** A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn’t cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

**Out-of-network provider or Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. **Chapter 3** of your *Member Handbook* explains out-of-network providers or facilities.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans that do not have cost sharing delete this paragraph.]* **Out-of-pocket costs:** The cost sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost sharing” above.

**Over-the-counter (OTC) drugs:** Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

**Part A:** Refer to “Medicare Part A.”

**Part B:** Refer to “Medicare Part B.”

**Part C:** Refer to “Medicare Part C.”

**Part D:** Refer to “Medicare Part D.”

**Part D drugs:** Refer to “Medicare Part D drugs.”

**Personal health information (also called Protected health information) (PHI):**

Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

*[Plans that do not use PCPs may omit this paragraph.]* **Primary care provider (PCP):** The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your *Member Handbook* for information about getting care from primary care providers.

**Prior authorization (PA):** *[Plans may delete applicable words or sentences if it does not require PA for any medical services or any drugs.]* An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of your *Member Handbook*.

Our plan covers some drugs only if you get PA from us.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs*.

**Program for All-Inclusive Care for the Elderly (PACE):** A program that covers Medicare and Medicaid benefits together for people age 55 and older who need a higher level of care to live at home.

**Prosthetics and Orthotics:** Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Quality improvement organization (QIO):** A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Member Handbook* for information about the QIO.

**Quantity limits:** A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

**Referral:** A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of your *Member Handbook*.

**Rehabilitation services:** Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Member Handbook* to learn more about rehabilitation services.

**Service area:** A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get our plan.

*[Insert if applicable]* **Share of cost:** The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

**Skilled nursing facility (SNF):** A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

**Skilled nursing facility (SNF) care:** Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

**Specialist:** A doctor who provides health care for a specific disease or part of the body.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



**State Fair Hearing:** If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Fair Hearing. If the State Fair Hearing is decided in your favor, we must give you the service you asked for.

**Commented [BW3]:** Our state and stakeholders all call these, "State Fair Hearings." Can we modify this term accordingly?

**Step therapy:** A coverage rule that requires you to try another drug before we cover the drug you ask for.

**Supplemental Security Income (SSI):** A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently needed care:** Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans may add a back cover for the Member Handbook that contains contact information for Member Services. Below is an example plans may use. Plans also may add a logo and/or photographs, as long as these elements do not make it difficult for members to find and read the contact information.]*

## <Plan name> Member Services

|                |                                                                                                                                                                                                                                                                                             |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <i>[Insert phone number(s).]</i><br><br>Calls to this number are free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i><br><br>Member Services also has free language interpreter services available for non-English speakers.    |
| <b>TTY</b>     | <i>[Insert number.]</i><br><br><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i><br><br>Calls to this number are free. <i>[Insert days and hours of operation.]</i> |
| <b>FAX</b>     | <i>[Optional: Insert fax number.]</i>                                                                                                                                                                                                                                                       |
| <b>WRITE</b>   | <i>[Insert address.]</i><br><br><i>[Note: Plans may add email addresses here.]</i>                                                                                                                                                                                                          |
| <b>WEBSITE</b> | <i>[Insert URL.]</i>                                                                                                                                                                                                                                                                        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.*

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## Instructions to Health Plans

- ❖ *[Plans may include the ANOC in the 2024 Member Handbook (Evidence of Coverage) or provide it to members separately.]*
- ❖ *[Plans may modify the language in the ANOC, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]*
- ❖ *[Plans must use the state-specific name for Medicaid in references to “Medicaid” in any plan-customized language throughout the ANOC.]*
- ❖ *[Throughout the document update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medicaid plans, etc.).]*
- ❖ *[Where the ANOC uses “medical care,” “medical services,” or “health care services” to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]*
- ❖ *[Plans may change references to terms such as “member,” “customer,” “beneficiary,” “enrollee,” “member services,” “care coordinator,” “primary care provider,” “prior authorization (PA)” as instructed by the state or based on plan preference and update them consistently throughout the ANOC.]*
- ❖ *[Where the model material instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]*
- ❖ *[Throughout the ANOC, plans must follow the applicable style rules of the state, if any. For instance, where the model material instructs inclusion of a date or time, plans must use the specific format requested by the state Medicaid program. Other items covered by a state-specific style guide or similar document should also be updated accordingly.]*
- ❖ *[Plans should refer to the Member Handbook as needed using the appropriate chapter number, section, and/or page number. For example, “refer to Chapter 9, Section A, page 1.” An instruction [insert reference, as applicable] appears with many cross references throughout the ANOC and Member Handbook. Plans may*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

- ❖ *[Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*
  - *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).*
  - *Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.*
  - *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
  - *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.*
  - *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
  - *Avoid separating a heading or subheading from the text that follows when paginating the model.*
  - *Use universal symbols or commonly understood pictorials.*
  - *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
  - *Consider using regionally appropriate terms or common dialects in translated models.*
  - *Include instructions and navigational aids in translated models in the translated language rather than in English.*
  - *Consider producing translated models in large print.]*



<Plan name> [insert plan type] offered by [insert sponsor name]

# Annual Notice of Changes for 2024

[Optional: insert member name]

[Optional: insert member address]

## Introduction

[If there are any changes to the plan for 2024, insert: You are currently enrolled as a member of our plan. Next year, there will be some changes to our [insert as applicable: benefits, coverage, rules, [and] costs]. This [insert as applicable: section or Annual Notice of Changes] tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at [insert URL]. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.]

[If there are no changes whatsoever for 2024 (e.g., no changes to benefits, coverage, rules, costs, networks), insert: You are currently enrolled as a member of our plan. Next year, there are no changes to our benefits, coverage, [and] rules [insert if applicable: and costs]. However, you should still read this [insert as applicable: section or Annual Notice of Changes] to learn about your coverage choices. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at [insert URL]. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.]

[Any plan that does not include a particular section (e.g., Section C, Section F) deletes the section, orders all remaining sections and subsections sequentially, and updates the Table of Contents accordingly. Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Disclaimers

- ❖ *[Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidance and included in any state-specific guidance provided by <insert state>.] [Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, here.]*

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## B. Reviewing your Medicare and *[Insert name of Medicaid program]* coverage for next year

It is important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section E** for more information.

If you choose to leave our plan, your membership will end on the last day of the month in which your request was made. You will still be in the Medicare and *[Insert name of Medicaid program]* programs as long as you are eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section G2** *[insert reference, as applicable]*.
- *[Insert name of Medicaid program]* services in **Section G2** *[insert reference, as applicable]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B1. Additional resources

- ATTENTION: If you speak *[insert language of the disclaimer]*, language assistance services, free of charge, are available to you. Call *[insert Member Services toll-free phone and TTY numbers, and days and hours of operation]*. The call is free. *[This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation.]*
- You can get this *[Insert as applicable: section or Annual Notice of Changes]* for free in other formats, such as large print, braille, or audio. Call *[insert Member Services toll-free phone and TTY numbers, and days and hours of operation]*. The call is free.
- *[Plans also simply describe:*
  - *how they request a member's preferred language other than English and/or alternate format,*
  - *how they keep the member's information as a standing request for future mailings and communications so the member does not need to make a separate request each time, and*
  - *how a member can change a standing request for preferred language and/or format.]*

## B2. Information about *<plan name>*

- *[Insert plan's legal or marketing name]* is a health plan that contracts with both Medicare and Medicaid to provide benefits of both programs to members.
- Coverage under *[insert plan name]* is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.
- When this *Annual Notice of Changes* says "we," "us," "our," or "our plan," it means *[insert plan name]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



### B3. Important things to do

- **Check if there are any changes to our benefits** *[insert if applicable: and costs]* that may affect you.
  - Are there any changes that affect the services you use?
  - Review benefit *[insert if applicable: and cost]* changes to make sure they will work for you next year.
  - Refer to **Section E1** for information about benefit *[insert if applicable: and cost]* changes for our plan.
- **Check if there are any changes to our prescription drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different *[insert if applicable: cost-sharing]* tier? Can you use the same pharmacies?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section E2** for information about changes to our drug coverage.
  - *[All plans with any Medicare Part D cost sharing insert: Your drug costs may have risen since last year.*
    - Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year.
    - Keep in mind that your plan benefits determine exactly how much your own drug costs may change.]
- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section D** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
  - *[Insert if applicable: How much will you spend out-of-pocket for the services and prescription drugs you use regularly?]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- How do the total costs compare to other coverage options?
- **Think about whether you are happy with our plan.**

**If you decide to stay with <2024 plan name>:**

If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in <2024 plan name>.

**If you decide to change plans:**

*[Plans should revise this paragraph as necessary]* If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section G2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

---

**C. Changes to our plan name**

*[Plans that are not changing the plan name, delete this section. Plans with an anticipated name change at a time other than January 1 may modify the date below as necessary.]*

On January 1, 2024, our plan name changes from <2023 plan name> to <2024 plan name>.

*[Insert language to inform members whether they will get new plan ID cards and how, as well as how the name change affects any other member communication.]*

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**D. Changes to our network providers and pharmacies**

*[Plans with no changes to network providers and pharmacies insert: We have not made any changes to our network of providers and pharmacies for next year.]*

However, it's important that you know that we may make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook*.

*[Plans with changes to provider and/or pharmacy networks, insert: Our [insert if applicable: provider] [and] [insert if applicable: pharmacy] network[s] [insert as applicable: has or have] changed for 2024.]*

Please **review the 2024 Provider and Pharmacy Directory** to find out if your providers or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

website at <web address>. You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook*.]

---

**E. Changes to benefits [insert if applicable: and costs] for next year**

**E1. Changes to benefits [insert if applicable: and costs] for medical services**

[If there are no changes in benefits or in cost sharing, replace the rest of the section with: There are no changes to your benefits [insert if applicable: or amounts you pay] for medical services. Our benefits [insert if applicable: and what you pay for these covered medical services] will be exactly the same in 2024 as they are in 2023.]

We're changing our coverage for certain medical services [insert if applicable: and what you pay for these covered medical services] next year. The table below describes these changes.

[The table must include:

- All new benefits that will be added or 2023 benefits that will end for 2024;
- New or changing limitations or restrictions, including prior authorizations (PA), on benefits for 2024; **and**
- All changes in cost sharing for 2024 for covered medical services, including any changes to service category out-of-pocket maximums.]



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                              | 2023 (this year)                                                                                                                                                                                                                                                                                               | 2024 (next year)                                                                                                                                                                                                                                                                                                  |
|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>[Insert benefit name]</i> | <i>[For benefits that were not covered in 2023, insert:<br/><br/>[insert benefit name] is <b>not</b> covered.]<br/><br/>[For benefits with a copay insert:<br/><br/>You pay a \$&lt;2023 copay amount&gt; copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].]</i> | <i>[For benefits that will not be covered in 2024, insert:<br/><br/>[insert benefit name] is <b>not</b> covered.]<br/><br/>[For benefits with a copay insert:<br/><br/>You pay a \$&lt;2024 copay amount&gt; copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].]</i> |
| <i>[Insert benefit name]</i> | <i>[Insert 2023 cost or coverage, using format described above.]</i>                                                                                                                                                                                                                                           | <i>[Insert 2024 cost or coverage, using format described above.]</i>                                                                                                                                                                                                                                              |

**E2. Changes to prescription drug coverage**

**Changes to our Drug List**

*[Plans that did not include a List of Covered Drugs in the envelope, insert: You will get a 2024 List of Covered Drugs in a separate mailing.]*

*[Plans that did not include a List of Covered Drugs in the envelope and will not mail it separately unless requested, insert: An updated List of Covered Drugs is located on our website at <web address>. You may also call Member Services at the numbers at the bottom of the page for updated drug information or to ask us to mail you a List of Covered Drugs.]*

*[Plans that included a List of Covered Drugs in the envelope, insert: We sent you a copy of our 2024 List of Covered Drugs in this envelope.] The List of Covered Drugs is also called the “Drug List.”*

*[Plans with no changes to covered drugs, tier assignment, or restrictions may replace the rest of this section with: We have not made any changes to our Drug List for next year. However, we are allowed to make changes to the Drug List from time to time throughout the year, with approval from Medicare and/or the state. Refer to the 2024 Drug List for more information.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs.

Review the Drug List to **make sure your drugs will be covered next year** and to find out if there are any restrictions.

If you are affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
  - You can call Member Services at the numbers at the bottom of the page [\[insert if applicable: or contact your care coordinator\]](#) to ask for a list of covered drugs that treat the same condition.
  - This list can help your provider find a covered drug that might work for you.
- [\[Plans should include the following language if they have an advance transition process for current members:\]](#) Work with your doctor (or other prescriber) and ask us to make an exception to cover the drug.
  - You can ask for an exception before next year, and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement).
  - To learn what you must do to ask for an exception, refer to **Chapter 9** of your *Member Handbook* or call Member Services at the numbers at the bottom of the page.
  - If you need help asking for an exception, contact Member Services [\[insert if applicable: or your care coordinator\]](#). Refer to **Chapters 2 and 3** of your *Member Handbook* to learn more about how to contact your care coordinator.
- [\[Plans should include the following language if all current members will not be transitioned in advance for the following year:\]](#) Ask us to cover a temporary supply of the drug.
  - In some situations, we cover a **temporary** supply of the drug during the first [\[must be at least 90\]](#) days of the calendar year.
  - This temporary supply is for up to [\[insert supply limit \(must be the number of days in plan's one-month supply\)\]](#) days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
  - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

different drug our plan covers or ask us to make an exception for you and cover your current drug.

*[Plans may include additional information about processes for transitioning current enrollees to formulary drugs when your formulary changes relative to the previous plan year.]*

*[Include language to explain whether current formulary exceptions will still be covered next year or a new one needs to be submitted.]*

**Changes to prescription drug costs** *[option for plans with two drug payment stages]*

*[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), should include the following information in the ANOC.]*

*[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]*

There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

| Stage 1<br>Initial Coverage Stage                                                                                                                                                                        | Stage 2<br>Catastrophic Coverage Stage                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay.<br><br>You begin this stage when you fill your first prescription of the year. | During this stage, the plan pays all of the costs of your drugs through December 31, 2024.<br><br>You begin this stage after you pay a certain amount of out-of-pocket costs. |

The Initial Coverage Stage ends when your total out-of-pocket costs for prescription drugs reaches *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you will pay for prescription drugs.

**E3. Stage 1: “Initial Coverage Stage”**

During the Initial Coverage Stage, our plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

**Commented [BW1]:** For 2023, there was text added via a 9/6/22 HPMS memo related to the Inflation Reduction Act. We wanted to point it out in case CMS would like to add it back here.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Insert if applicable: We moved some of the drugs on our Drug List to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our Drug List.]*

The following table shows your costs for drugs in each of our *[insert number of tiers]* drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

*[Plans must list all drug tiers in the following table.]*

|                                                                                                                                                                                                                           | 2023 (this year)                                                                                                                                           | 2024 (next year)                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |

The Initial Coverage Stage ends when your total out-of-pocket costs reach *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point the Catastrophic Coverage Stage begins. The plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information how much you pay for prescription drugs.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**E4. Stage 2: “Catastrophic Coverage Stage”**

When you reach the out-of-pocket limit *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]* for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year.

- *[Plans that do not reduce the copays for [insert name of the Medicaid program]-covered drugs in the catastrophic coverage stage should insert the following language: To locate more information about your prescriptions that Medicare and [insert name of the Medicaid program] cover, refer to the List of Covered Drugs, [insert reference, as applicable].]*

**Changes to prescription drug costs** *[option for plans with a single payment stage]*

*[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following information.]*

*[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]*

*[Insert if applicable: We moved some of the drugs on the Drug List to a lower or higher drug tier. [Insert if applicable: If your drugs move from tier to tier, this could affect your copay.] To find out if your drugs are in a different tier, look them up in the Drug List.]*

The following table shows your costs for drugs in each of our *[insert number of tiers]* drug tiers.

*[Plans must list all drug tiers in the following table.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



|                                                                                                                                                                                                                           | 2023 (this year)                                                                                                                                           | 2024 (next year)                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |

**F. Administrative changes**

*[Insert this section if applicable. Plans with administrative changes that impact members (e.g., change in contract or PBP number) may insert this section, include an introductory sentence that explains the general nature of administrative changes, and describe the specific changes in the table below. Plans that choose to omit this section should renumber the remaining sections as needed.]*

|                                                                                   | 2023 (this year)                                | 2024 (next year)                                |
|-----------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <i>[Insert a description of the administrative process/item that is changing]</i> | <i>[Insert 2023 administrative description]</i> | <i>[Insert 2024 administrative description]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                   | 2023 (this year)                                | 2024 (next year)                                |
|-----------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <i>[Insert a description of the administrative process/item that is changing]</i> | <i>[Insert 2023 administrative description]</i> | <i>[Insert 2024 administrative description]</i> |

## G. Choosing a plan

### G1. Staying in our plan

We hope to keep you as a plan member. You do not have to do anything to stay in our plan. If you do **not** change to another Medicare plan or change to Original Medicare, you automatically stay enrolled as a member of our plan for 2024.

### G2. Changing plans

*[Plans should add any additional Medicaid information as directed by the state.]* Most people with Medicare can end their membership during certain times of the year. Because you have *[Insert name of Medicaid program]*, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You moved out of our service area,
- Your eligibility for *[Insert name of Medicaid Program]* or Extra Help changed, or

**Commented [BW2]:** As we also note in Chapter 10, at present we do not use these SEPs in any of our programs, so this one would be the first, and it would require reprogramming, testing, and extensive education and outreach about this change.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

**Your Medicare services**

You have three options for getting your Medicare services. By choosing one of these options, you automatically end your membership in our plan. *[Insert additional option to change to another integrated program as directed by the state.]*

|                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>1. You can change to:</b></p> <p><b>Another Medicare health plan</b> <i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>For PACE inquiries, call 1-855-921-PACE (7223).</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call the <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i> For more information or to find a local <i>[insert name of SHIP office]</i> office in your area, please visit <i>[insert website address]</i>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare plan.</p> <p>You will automatically be disenrolled from our plan when your new plan’s coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>2. You can change to:</b></p> <p><b>Original Medicare with a separate Medicare prescription drug plan</b></p> <p><i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i> For more information or to find a local <i>[insert name of office]</i> office in your area, please visit <i>[insert website address]</i>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare prescription drug plan.</p> <p>You will automatically be disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>3. You can change to:</b></p> <p><b>Original Medicare without a separate Medicare prescription drug plan</b></p> <p><i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> <p><b>NOTE:</b> If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join.</p> <p>You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i></li></ul> <p>You will automatically be disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Your *[insert name of state Medicaid program]* services**

For questions about how to get your *[insert name of Medicaid program]* services after you leave our plan, contact *[insert name of program, phone number, days and hours of operation, and TTY number and website if applicable]*. Ask how joining another plan or returning to Original Medicare affects how you get your *[insert name of Medicaid program]* coverage.

**Commented [BW3]:** We anticipate directing members to our enrollment broker's call center which plays this role today.

**H. Getting help**

**H1. Our plan**

We're here to help if you have any questions. Call Member Services at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

**Read your *Member Handbook***



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits *[insert if applicable: and costs]* for 2024. It explains your rights and the rules to follow to get services and prescription drugs we cover.

*[If the ANOC is sent or provided separately from the Member Handbook, include the following: The Member Handbook for 2024 will be available by October 15.] [Insert if applicable: You can also review the <attached or enclosed or separately mailed> Member Handbook to find out if other benefit [insert if applicable: or cost] changes affect you.]* An up-to-date copy of the *Member Handbook* is available on our website at *<web address>*. You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2024.

#### Our website

You can visit our website at *<web address>*. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our Drug List (*List of Covered Drugs*).

#### H2. *[Insert name of the State Health Insurance Assistance Program (SHIP)]*

You can also call the State Health Insurance Assistance Program (SHIP). In *[Insert name of state]* the SHIP is called the *[Insert name of program]*. *[Insert name of program staff]* can help you understand your plan choices and answer questions about switching plans. *[Insert name of program]* ~~HICAP~~ is not connected with us or with any insurance company or health plan. *[Insert name of program]* has trained counselors *[insert in every county or locations]* and services are free. *[Insert name of program]* phone number is *[TTY phone number is optional.]* For more information or to find a local *[Insert name of program]* office in your area, please visit *[insert website address]*.

**Commented [BW4]:** Our first referral after the plan would probably not be to the SHIP, which seems to play a more limited role in our state than others based on its prominence in these draft models.

First, members should call our enrollment broker, which operates a call center and is trained on these topics. They are neither the SHIP nor the ombudsman. Can we please have the flexibility to include them before the SHIP?

**Commented [BW5]:** Remove a state-specific reference

#### H3. *[Insert State-specific name for ombudsman program]*

*[Insert this section if there is an ombudsman program in the state. Include a description of what the program can do, whether the services are free, and phone number. Please refer to an example of language below.]*

[Optional language example: *The Ombudsman Program can help you if you have a problem with our plan. The ombudsman's services are free and available in all languages. The Ombudsman Program:*

- *Works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do.*
- *Makes sure you have information related to your rights and protections and how you can get your concerns resolved.*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Is not connected with us or with any insurance company or health plan. The phone number for the Ombudsman Program is [insert phone number].*

#### **H4. Medicare**

To get information directly from Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

##### **Medicare's Website**

You can visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to [www.medicare.gov](http://www.medicare.gov) and click on "Find plans.")

##### **Medicare & You 2024**

You can read the *Medicare & You 2024* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf](http://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf)) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

*[Insert any additional sections as required by the state, such as the QIO or additional resources that might be available.]*

#### **H5. [Insert state-specific name of Medicaid program.]**

*[Insert a description of the state Medicaid program's role and how to receive assistance from the state.]*

#### **H6. [Insert additional resources if applicable]**

*[If applicable, insert a new section for each additional resource, including contact information and a description of their role.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Our state offers these comments with the understanding that our current demonstration program will continue as-is for some time, and any future plans – or comments in this document – are speculative and tentative.*

Formatted: Font: 10 pt

<Plan name> MEMBER HANDBOOK

## <Plan name> **Member Handbook**

- ❖ *[Plans may add a front cover to the Member Handbook that contains information such as the plan name, Member Handbook title, and contact information for Member Services. Plans may add a logo and/or photographs to the front cover as long as these elements do not make it difficult for members to read other information on the cover. If plans add a front cover, it must contain the Material ID.]*
- ❖ *[Plans must use the state-specific name for Medicaid in references to "Medicaid" in any plan-customized language throughout the Member Handbook.]*
- ❖ *[Plans may modify the language in the Member Handbook, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]*
- ❖ *[Throughout the document plans should update language based on how the integrated program is described in the state as instructed by the state (i.e., one name for the plan or matching Medicare and Medicaid plans, etc.)]*
- ❖ *[Where the Member Handbook uses "medical care," "medical services," or "health care services" to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]*
- ❖ *[Plans may change references to terms such as "member," "customer," "beneficiary," "member services," "health risk assessment," "care coordinator," "primary care provider," "prior authorization (PA)," "nursing facility", and "urgently needed care", etc. as instructed by the state or based on plan preference and update them consistently throughout the Member Handbook.]*
- ❖ *[Where the model material instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]*
- ❖ *[Throughout the Member Handbook, in addition to following all Medicare and Medicaid requirements in regulation and the Medicare Communications and Marketing Guidelines, plans must follow additional applicable style rules of the state, if any.]*
- ❖ *[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number as appropriate. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional*

**Commented [BW1]:** We may have nuances around use of "Healthy Connections Medicaid," "Healthy Connections <Program Name>", etc.

**Commented [BW2]:** This is very helpful flexibility; thank you.

**Commented [BW3]:** Believe this should be "e.g." (for example) rather than limiting us to "i.e." (that is), especially since some flexibility is implied by the "etc." at the end.

**Commented [BW4]:** Thank you; we prefer to use "nursing home" in all documents.

**Commented [BW5]:** Thank you for this! This is how we expect to inform plans of our preferred terms ("member," "primary care provider," etc.) unless CMS has another preference for method.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.



*references to other sections, chapters, and/or member materials when helpful to the reader.]*

- ❖ *[Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*
  - *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).*
  - *Ensure plan-customized text is in plain language and complies with reading level requirements **established in by the state**.*
  - *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
  - *Spell out an acronym or abbreviation before its first use in a **document or on a page** (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.*
  - *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
  - *Avoid separating a heading or subheading from the text that follows when paginating the model.*
  - *Use universal symbols or commonly understood pictorials.*
  - *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
  - *Consider using regionally appropriate terms or common dialects in translated models.*
  - *Include instructions and navigational aids in translated models in the translated language rather than in English.*
  - *Consider producing translated models in large print.]*

**Commented [BW6]:** Is there a typo or missing word here?

**Commented [BW7]:** Suggest making this "in a chapter" – we would rather have them explained a few times throughout the lengthy Member Handbook, but not necessarily on every page.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

<start date> – <end date>

## Your Health and Drug Coverage under <plan name>

*[Plans: Revise this language to reflect that the organization is providing both Medicaid and Medicare covered benefits, when applicable.]*

*[Optional: Insert member name.]*

*[Optional: Insert member address.]*

### **Member Handbook Introduction**

This *Member Handbook*, otherwise known as the *Evidence of Coverage*, tells you about your coverage under our plan through <end date>. It explains health care services *[plans may add references to other behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports, as needed]*. Key terms and their definitions appear in alphabetical order in Chapter 12 of your *Member Handbook*.

**This is an important legal document. Keep it in a safe place.**

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means *[insert plan name]*.

ATTENTION: If you speak *[insert language of the disclaimer]*, free language assistance services are available to you. Call <plan name> Member Services at the number at the bottom of this page. The call is free. *[This disclaimer must be included in all non-English languages that meet the Medicare or state thresholds for translation.]*

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

*[Plans also simply describe:*

- *how they request a member's preferred language other than English and/or alternate format,*
- *how they keep the member's information as a standing request for future mailings and communications so the member does not need to make a separate request each time, **and***
- *how a member can change a standing request for preferred language and/or format.]*

*[Plans must include an overall Table of Contents for the Member Handbook after the Member Handbook Introduction and before the Member Handbook Disclaimers.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Disclaimers

- ❖ *[Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidelines, and included in any state-specific guidance.]*
- ❖ *[Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, [here](#).]*
- ❖ Coverage under *[insert plan name]* is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 1: Getting started as a member

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### Introduction

This chapter includes information about *[insert plan name]*, a health plan that *[insert description of the relationship such as covers or coordinates]* all of your Medicare and *[insert name of Medicaid program]* services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

|                                                                                  |    |
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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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K. Keeping your membership record up to date ..... 15

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---

## A. Welcome to our plan

*[Insert language to describe the relationship between the Medicare and Medicaid services. For example: Our plan provides Medicare and [insert name of Medicaid program] services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.]*

*[Plan can include language about itself.]*

---

## B. Information about Medicare and *[Insert name of Medicaid Program]*

### B1. Medicare

Medicare is the federal health insurance program for:

- People 65 years of age or older,
- Some people under age 65 with certain disabilities, **and**
- People with end-stage renal disease (kidney failure).

### B2. *[Insert name of Medicaid Program]*

*[Insert name of the Medicaid program]* is the name of *[insert name of state]* Medicaid program. *[Insert name of Medicaid program]* is run by the state and is paid for by the state and the federal government. *[Insert name of Medicaid program]* helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- What counts as income and resources,
- Who is eligible,
- What services are covered, **and**
- The cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

*[Plans should revise this section to best reflect the coverage of the plan.]* Medicare and the state of *[insert name of state]* approved our plan. You can get Medicare and *[insert name of state Medicaid program]* services through our plan as long as:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We choose to offer the plan, **and**
- Medicare and the State of *[insert name of state]* allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and *[insert name of state program]* services is not affected.

---

## C. Advantages of our plan

*[Plans should revise this section to best reflect the coverage of the plan.]* You will now get all your covered Medicare and *[Insert name of Medicaid program]* services from our plan, including prescription drugs. **You do not pay extra to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **all** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

---

## D. Our plan's service area

*[Insert plan service area here or within an appendix. Include a map if one is available.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Use county name only if approved for entire county, for example: Our service area includes these counties in <State>: <counties>.*

*For an approved partial county, use county name plus ~~approved~~ ZIP code(s) that are excluded, for example: Our service area includes all parts of <county> with the exception of the following ZIP code(s): <ZIP code(s)>.*

**Commented [BW8]:** "Approved ZIP codes that are excluded" is awkward; suggest deleting "approved."

*If needed, plans may insert a table with more than one row or a short, bulleted list to describe and illustrate their service area in a way that is easy to understand.]*

Only people who live in our service area can join our plan.

**You cannot stay in our plan if you move outside of our service area.** Refer to **Chapter 8** of your *Member Handbook* for more information about the effects of moving out of our service area.

## E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- Live in our service area, **and**
- Have both Medicare Part A and Medicare Part B, **and**
- *Are currently eligible for [insert name of state Medicaid program], and*
- *[Insert any Medicaid requirements], and*
- Are a United States citizen or are lawfully present in the United States.

**Commented [BW9]:** We have a fairly detailed list of these in our current program, and being able to put this at the end of the list after citizenship requirements would be less confusing for members, so they don't have to parse sub-bullets and then jump back to "citizen or lawfully present"

If you lose eligibility but can be expected to regain it within *[Insert number 1-6]*, *Plans may choose any length of time from one to six months for deeming continued eligibility, as long as they apply the criteria consistently across all members and fully inform members of the policy.]* month(s), then you are still eligible for our plan.

**Commented [BW10]:** Presently, our state uses 60 days, which is similar to but not exactly two months. However, we do not want plans to choose a length; this needs to be determined by Medicaid policy and consistent across plans.

Call Member Services for more information.

## F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date *[Plans adjust this language if the state requirement is more stringent]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs *[add additional areas covered by HRA]*.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, *or mail.*

We'll send you more information about this HRA.

*[Plans may add additional language regarding information about joining the plans as directed by the state such as information about a continuity of care period or using doctors for a transition period.]*

**Commented [BW11]:** This would be a change for us and we are curious how it works. What happens if a member ignores a mail HRA? Is there a penalty or a tracked performance measure for plans? Are they expected to follow up by other means?

**Commented [BW12]:** Thank you for this flexibility.

## G. Your care team and care plan

### G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, or other health person that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

### G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and *[Insert as applicable: LTSS or other services]*.

Your care plan includes: *[Update the description of the care plan and the process as outlined in your model of care (MOC)]*.

- Your health care goals.
- A timeline for getting the services you need.

Your care team meets with you after your health risk assessment. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H. Your monthly costs for *[insert plan name]*

*[Plans should revise this section to only include premium types that apply or delete if plan has no monthly premium and revise with “Our plan has no premium.”]*

Your costs may include the following:

- Plan premium (Section H.1)
- Monthly Medicare Part B Premium (Section H.2)
- Optional Supplemental Benefit Premium (Section H.3)

**In some situations, your plan premium could be less.**

*[Insert as appropriate, depending on whether SPAPs are discussed in Chapter 2: There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. OR The “Extra Help” program helps people with limited resources pay for their drugs.]* Chapter 2, Section H2 tells more about *[insert as applicable: these programs OR this program.]* If you qualify, enrolling in the program might lower your monthly plan premium.

If you *already enrolled* and are getting help from one of these programs, **the information about premiums in this *Member Handbook* *[insert as applicable: may OR does]* not apply to you.** *[If not applicable, omit information about the LIS Rider.]* We *[insert as appropriate: have included OR sent you]* a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

### H1. Plan premium

*[If applicable, plans should revise this section to indicate that the plan premium is paid on behalf of members (e.g. by “Extra Help”, Medicaid).]*

As a member of your plan, you pay a monthly plan premium. *[Select one of the following: For 2024, the monthly premium for *[insert 2024 plan name]* is *[insert monthly premium amount]*. OR The monthly premium amount for *[insert 2024 plan name]* is listed in *[describe attachment.]* *[Plans may insert a list or table with the state/region and monthly plan premium amount for each area included within the EOC. Plans may also include premium(s) in an attachment to the EOC.]**

*[Plans with no premium should delete this section.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H2. Monthly Medicare Part B Premium

### Many members are required to pay other Medicare premiums

*[Plans that include a Medicare Part B premium reduction benefit may describe the benefit within this section.]*

*[Plans that do not have any members paying Medicare premiums or plans whose members must pay the full Medicare Part B premium should modify this section.]*

*[Plans with no monthly premium, omit: In addition to paying the monthly plan premium,]* some members are required to pay other Medicare premiums. As explained in Section H2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most *[insert 2024 plan name]* members, Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and for your Medicare Part B premium.

**If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.** This includes your premium for Medicare Part B. It may also include a premium for Medicare Part A which affects members who aren't eligible for premium free Medicare Part A. **In addition, please contact Member Services or your care coordinator and inform them of this change.**

### H3. Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called "optional supplemental benefits," then you pay additional premium each month for these extra benefits. Refer to Chapter 4, Section E for details. *[If the plan describes optional supplemental benefits within Chapter 4, then the plan must include the premium amounts for those benefits in this section.]*

**Commented [BW13]:** At present, our plans can and do offer some supplemental benefits at no cost. We want to be sure the instructions are flexible for plans to indicate a no-cost option as well.

## I. Your Member Handbook

Your *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* found on our website *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

The contract is in effect for the months you are enrolled in our plan between *[insert start date]* and *[insert end date]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

---

## J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, *[insert if applicable: information about how to access]* a *Provider and Pharmacy Directory*, *[plans that limit DME brands and manufacturers insert: a List of Durable Medical Equipment,]* and *[insert if applicable: information about how to access]* a *List of Covered Drugs*, also known as a *Formulary*.

### J1. Your Member ID Card

Under our plan, you have one card for your Medicare and *[insert name of Medicaid program]* services, including long-term services and supports, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:

*[Insert picture of front and back of plan ID card. Mark it as a sample card (for example, by superimposing the word “sample” on the image of the card).]*

If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your *[insert name of Medicaid program]* card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Member Handbook* to find out what to do if you get a bill from a provider.

*[If members must use a different card for any Medicaid services, include a description here.]*

### J2. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Provider and Pharmacy Directory* at *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

*[Plans must add information describing the information available in the directory.]*

*[Plans may add information describing the use of providers during a transition period as directed by the state.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Definition of network providers**

- Our network providers include:
  - Doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - LTSS, behavioral health services, home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

**Definition of network pharmacies**

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to [\[insert if applicable: help you\]](#) pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

*[Plans that limit DME brands and manufacturers insert the following section (for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual:*

**List of Durable Medical Equipment (DME)**

We sent you our List of Durable Medical Equipment (DME) with this *Member Handbook*. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at the address at the bottom of the page. Refer to **Chapters 3 and 4** of your *Member Handbook* to learn more about DME equipment.]

**J3. List of Covered Drugs**

The plan has a *List of Covered Drugs*. We call it the “Drug List” for short. It tells you which prescription drugs our plan covers.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Member Handbook* for more information.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Each year, we send you [\[insert if applicable: information about how to access\]](#) the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website [at the address at the bottom of the page](#). [\[Plans may insert information about Medicaid covered drugs.\]](#)

#### J4. The Explanation of Benefits

When you use your Medicare Part D prescription drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D prescription drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take [\[insert, as applicable: such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options\]](#).

**Chapter 6** of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

[\[Plans may insert other methods for members to get their EOB.\]](#)

---

## K. Keeping your membership record up to date

[\[In the Table of Contents, section heading, and text, plans substitute the name for this file if it differs from "membership record."\]](#)

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you.**

Tell us right away about the following:

- Changes to your name, your address, or your phone number.
- Changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation.
- Any liability claims, such as claims from an automobile accident.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Admission to a nursing facility or hospital.
- Care from a hospital or emergency room.
- Changes in your caregiver (or anyone responsible for you.)
- You take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

*[Plans that allow members to update this information online may describe that option here.]*

*[Plans may add information regarding keeping their Medicaid information updated as directed by the state.]*

### **K1. Privacy of personal health information (PHI)**

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



A National Nonprofit Leadership Organization

VIA ELECTRONIC SUBMISSION

[www.federalregister.gov](http://www.federalregister.gov)

November 7, 2022

**RE: CMS 10824 – Annual Notice of Chance and Evidence of Coverage for Applicable Integrated Plans in States that Require Integrated Materials**

**Agency: Centers for Medicare and Medicaid Services (CMS), HHS**

**Introduction**

The SNP Alliance is a national membership organization dedicated to improving policy and practice of MA Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). The SNP Alliance's 26 member health plans serve over 2.8 million special needs individuals in 47 states and the District of Columbia, most of whom are dually eligible for both Medicare and Medicaid. We appreciate the opportunity to comment on the proposed Integrated Annual Notice of Changes (ANOC) and Evidence of Coverage (EOC).

**SNP Alliance Comments of Support**

The SNP Alliance supports the proposed changes to the ANOC and EOC for D-SNPs that are applicable integrated plans (AIPs). CMS properly notes there are advantages to receiving communications that integrate all the required Medicare and Medicaid content, including providing a more seamless description of health care coverage and enhancing the understanding of, and satisfaction with, the coverage both programs provide. The SNP Alliance has long advocated the integration of member materials as important for improving the beneficiary experience and outcomes. We appreciate the actions taken here to advance integration.

**SNP Alliance Concerns**

The SNP Alliance would like to highlight a number of concern and recommendations in the following sections:

1. Instructions to Health Plans
2. Chapter 4: Benefits Chart
3. Chapter 5: Getting Your Outpatient Drugs

In summary, some of the language does not appear flexible enough to account for unique situations and policies for certain D-SNPs and State Medicaid programs. Specific examples are below.

***Instructions to Health Plans***

1. **E2. Changes to Prescription Drug Coverage.** The below statement in section E2 (page 12) for payment stages only allows for single and two payment stage charts. Will there be an option to



include a four stage chart similar to the standard Part D model? If not, where would plans report changes to the coverage gap?

*There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:*

2. **E2. Changes to Prescription Drug Coverage.** In the below chart in section E2 (page 12), for plans that file \$0 RX on all tiers through VBID, would that be considered single stage?

| <b>Stage 1</b><br><b>Initial Coverage Stage</b>                                                                                                                                                                        | <b>Stage 2</b><br><b>Catastrophic Coverage Stage</b>                                                                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay.</i><br><br><i>You begin this stage when you fill your first prescription of the year.</i> | <i>During this stage, the plan pays all of the costs of your drugs through December 31, 2024.</i><br><br><i>You begin this stage after you pay a certain amount of out-of-pocket costs.</i> |

#### **Chapter 4: Benefits Chart**

1. **C. About Our Plan’s Benefits Chart.** The instructions below (page 4) mention SSBCI but do not mention VBID benefits. We recommend adding VBID benefits for D-SNPs that file VBID and to include the required WHP language.

*[Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI)” in section B-19 of the Plan Benefit Package submission: Important Benefit Information for Members with Certain Chronic Conditions. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [insert if applicable: and/or reduced cost sharing]:*

2. **D. Our Plan’s Benefits Chart.** In the *Services That Our Plan Pays For* chart beginning on page 6, there is some confusion about what a plan should do, and where the benefits should be listed, if the plan offers more services for a specific benefit, such as acupuncture, in the supplemental benefit, than it does in the Medicare-defined benefit. In short, if a supplemental benefit exceeds the Medicare-defined benefit, how and where should that be listed?

#### **Chapter 5: Getting Your Outpatient Drugs**

1. **B1. Drugs on our Drug List.** The below statement in Section B1 (page 10) will be an issue for some plans, as some plans operate in states where outpatient drugs are carved out of Medicaid plans and administered directly by the state or another entity.

*Our Drug List includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under [Insert name of state Medicaid program].*

2. **B3. Drugs Not on our Drug List.** It would not be feasible to list all excluded drugs (page 11). Is CMS expecting plans to list all excluded drugs? The below statement implies plans need to list all excluded drugs.

*Our plan does not pay for the drugs listed in this section. These are called excluded drugs. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to Chapter 9 of your Member Handbook for more information about appeals.*

3. **B3. Drugs Not on our Drug List.** Plans have the ability to cover drugs outside of Part D, which some plans are doing. CMS has listed some drugs as examples of excluded drugs (page 11), which health plans may cover outside of Part D. Listing of drugs the health plans may cover outside of Part D, as done in the statement below, may lead to beneficiary confusion over what drugs the health plan covers.

*Also, by law, Medicare or [Insert name of Medicaid program] cannot cover the types of drugs listed below.*

- *Drugs used to promote fertility*
- *Drugs used for cosmetic purposes or to promote hair growth*
- *Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®*
- *Outpatient drugs made by a company that says you must have tests or services done only by them*

### **Conclusion**

The SNP Alliance is committed to quality, excellence and health equity in service delivery to the individuals enrolled in our member plans. We appreciate this opportunity to provide comment and seek to work together to enhance the lives and well-being of all Americans—primarily those with complex needs. We are happy to answer any follow-up questions or provide additional information, should that be helpful.

Respectfully,



Cheryl Phillips, M.D. AGSF  
President and CEO  
Special Needs Plan Alliance  
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[www.snpalliance.org](http://www.snpalliance.org)

## Chapter 2: Important phone numbers and resources

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### Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[If applicable, plans should modify this chapter to include contact information for other resources.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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| H. Programs to Help People Pay for Their Prescription Drugs .....                                                                                                                                | 12 |
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| H2. State Pharmaceutical Assistance Program (SPAP) <i>[Plans in states without an SPAP or where the SPAP excludes enrollment of dual eligible individuals should delete this section.]</i> ..... | 13 |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

H3. AIDS Drug Assistance Program (ADAP) ..... 13

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J. Other resources..... 15



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## A. Member Services

**Commented [OME1]:** UnitedHealthcare (UHC) recommends remaining consistent with the current DSNP model as creating a whole new format and content creates risk in developing the documents and increases time required to manage additional templates.

|                |                                                                                                                                                                                                                                                               |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <Phone number(s)> This call is free.<br><Days and hours of operation> <i>[Include information on the use of alternative technologies.]</i><br>We have free interpreter services for people who do not speak English.                                          |
| <b>TTY</b>     | <TTY phone number> This call is free.<br><i>[Insert if the plan uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i><br><Days and hours of operation> |
| <b>FAX</b>     | <i>[Fax number is optional.]</i>                                                                                                                                                                                                                              |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                                                             |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                           |
| <b>WEBSITE</b> | <i>[Web URL.]</i>                                                                                                                                                                                                                                             |

Contact Member Services to get help with:

- Questions about the plan
- Questions about claims or billing

*[If plans have different numbers for the functions listed below, plans should insert separate charts with the additional contact information.]*

- Coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of your *Member Handbook* or contact Member Services.
- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (refer to **Section F** *[insert reference, as applicable]*).
  - You can call us and explain your complaint at <phone number>.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above *[insert reference, as applicable]*).
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - *[Insert additional instructions regarding how to make a complaint as directed by the state.]*
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Member Handbook*.
- Coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**
    - the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs *[insert if applicable, and name of Medicaid program prescription drugs and over-the-counter drugs]*.
  - For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above *[insert reference, as applicable]*.)
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Payment for health care or drugs you already paid for

*[Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits.]*

  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of your *Member Handbook*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B. Your Care Coordinator

*[Plans should include information explaining what a care coordinator is, how members can get a care coordinator, how they can contact the care coordinator, and how they can change their care coordinator. Plans can modify this section as appropriate.]*

|                |                                                                                                                                                                                                                                                                                                                             |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <p>&lt;Phone number(s)&gt; This call is free.</p> <p>&lt;Days and hours of operation&gt; <i>[Include information on the use of alternative technologies.]</i></p> <p>We have free interpreter services for people who do not speak English.</p>                                                                             |
| <b>TTY</b>     | <p>&lt;TTY phone number&gt; This call is <i>[insert if applicable: not]</i> free.</p> <p><i>[Insert if the plan uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i></p> <p>&lt;Days and hours of operation&gt;</p> |
| <b>FAX</b>     | <i>[Fax number is optional.]</i>                                                                                                                                                                                                                                                                                            |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                                                                                                                           |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                                                                                         |
| <b>WEBSITE</b> | <i>[Web address is optional.]</i>                                                                                                                                                                                                                                                                                           |

Contact your care coordinator to get help with:

- Questions about your health care
- Questions about getting behavioral health (mental health and substance use disorder) services
- Questions about transportation
- Questions about long-term services and supports (LTSS). LTSS includes *[Plans should insert information describing LTSS coverage.]*
- *[Plans may insert bullets noting additional areas that care coordinators can provide assistance with.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



### C. *[Insert State-specific Name of SHIP Program]*

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In *<insert state>*, the SHIP is called *<State-specific SHIP name>*.

*<Insert state-specific SHIP name>* is not connected with any insurance company or health plan.

|         |                                                                                                                                                                                                                               |
|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CALL    | <i>&lt;Phone number(s)&gt;</i><br><i>&lt;Days and hours of operation&gt;</i>                                                                                                                                                  |
| TTY     | <i>[TTY phone number is optional.]</i><br><i>[Insert if the SHIP uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| WRITE   | <i>&lt;Mailing address&gt;</i>                                                                                                                                                                                                |
| EMAIL   | <i>[Email address is optional.]</i>                                                                                                                                                                                           |
| WEBSITE | <i>&lt;Web address&gt;</i>                                                                                                                                                                                                    |

Contact *<insert name of SHIP program>* for help with:

- Questions about Medicare
- *<State-specific SHIP name>* counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.



**If you have questions**, please call *<plan name>* at *<toll-free phone and TTY numbers>*, *<days and hours of operation>*. The call is free. **For more information**, visit *<web address>*.

## D. Quality Improvement Organization (QIO)

Our state has an organization called <State-specific QIO name>. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. <State-specific QIO name> is not connected with our plan.

|                |                                                                                                                                                                                                                              |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <Phone number(s)>                                                                                                                                                                                                            |
| <b>TTY</b>     | <i>[TTY phone number is optional.]</i><br><i>[Insert if the QIO uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| <b>WRITE</b>   | <Mailing address>                                                                                                                                                                                                            |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                          |
| <b>WEBSITE</b> | <Web address>                                                                                                                                                                                                                |

Contact <State-specific QIO name> for help with:

- Questions about your health care rights
- Making a complaint about the care you got if you:
  - have a problem with the quality of care,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## E. 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, or CMS.

|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free, 24 hours a day, 7 days a week.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>TTY</b>     | 1-877-486-2048 This call is free.<br>This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>WEBSITE</b> | <a href="https://www.medicare.gov">medicare.gov</a><br>This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices.<br>It includes helpful websites and phone numbers. It also has documents you can print right from your computer.<br>If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you. |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**F. *[Insert name of Medicaid Program]***

*[Plans must adapt this generic discussion of Medicaid to reflect the name or features of the Medicaid program in the plan's state or states.]*

*[If there are two different agencies handling eligibility and coverage/services, the plan should include both and clarify the role of each.]*

*[Plans must, as appropriate, include additional telephone numbers for Medicaid program assistance.]*

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call <State-specific Medicaid agency>.

*[If applicable, plans may also inform members that they can get information about Medicaid from county resource centers and indicate where members can find contact information for these centers.]*

**Commented [OME2]:** UnitedHealthcare (UHC) recommends remaining consistent with the current DSNP model as creating a whole new format and content creates risk in developing the documents and increases time required to manage additional templates.

|                |                                                                                                                                                                                                                                                          |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <i>[Insert state-specific Medicaid agency]</i><br><Days and hours of operation>                                                                                                                                                                          |
| <b>TTY</b>     | <i>[Insert number, if available. Or delete this row.] [Insert if the state Medicaid program uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i> |
| <b>WRITE</b>   | <Insert Mailing address>                                                                                                                                                                                                                                 |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i>                                                                                                                                                                                                                      |
| <b>WEBSITE</b> | <a href="http://www.healthcareoptions.dhcs.ca.gov/">www.healthcareoptions.dhcs.ca.gov/</a><br><Insert Web URL>                                                                                                                                           |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**G. *[Insert State-specific name for ombudsman program]***

The *<State-specific name for ombudsman program>* works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. *<State-specific name for ombudsman program>* also helps you with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

**Commented [OME3]:** The DSNP model EOC includes a placeholder for state-specific long-term care (LTC) ombudsmen program. Is this not applicable to integrated plans?

|                |                                                                                                                                                                                                                                                       |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <p>&lt;Phone number(s)&gt;</p> <p>&lt;Days and hours of operation&gt;</p>                                                                                                                                                                             |
| <b>TTY</b>     | <p><i>[TTY phone number is optional.]</i></p> <p><i>[Insert if the ombudsman program uses a direct TTY number: This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.]</i></p> |
| <b>WRITE</b>   | <Insert Mailing address>                                                                                                                                                                                                                              |
| <b>EMAIL</b>   | <p><i>[Email address is optional.]</i></p> <p><a href="mailto:">mailto:</a></p>                                                                                                                                                                       |
| <b>WEBSITE</b> | <p>&lt;Insert Web URL&gt;</p> <p><a href="http://www.dhcs.ca.gov/services/medicaid/Pages/MMCDOfficeoftheOmbudsman.aspx">www.dhcs.ca.gov/services/medicaid/Pages/MMCDOfficeoftheOmbudsman.aspx</a></p>                                                 |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H. Programs to Help People Pay for Their Prescription Drugs

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

### H1. Extra Help

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything to get this “Extra Help.”

|                |                                                                                                                                                                    |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free, 24 hours a day, 7 days a week.                                                                   |
| <b>TTY</b>     | 1-877-486-2048 This call is free.<br>This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. |
| <b>WEBSITE</b> | <a href="https://www.medicare.gov">medicare.gov</a>                                                                                                                |

*[Plans that have no drug cost sharing may delete this section.]*

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your correct copayment level, or if you already have the evidence, to provide this evidence to us.

- *[Plans should insert process for allowing members to request assistance with obtaining best available evidence, and for providing this evidence.]*
- *[Plans should update this description to accurately reflect the process in this bullet.]* When we receive the evidence showing your copayment level, we will update our system so that you will be charged the correct copayment when you get your next prescription. If you overpay your copayment, we will pay you back. Either we will send a check to you or we will deduct the amount from future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owned by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have **questions**.

**Commented [OME4]:** The DSNP EOC Model includes the following language:

*[Other plans should use this language: Most of our members qualify for and are already getting “Extra Help” from Medicare to pay for their prescription drug plan costs.]*

Is this not applicable?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H2. **State Pharmaceutical Assistance Program (SPAP)** *[Plans in states without an SPAP or where the SPAP excludes enrollment of dual eligible individuals should delete this section.]*

**Commented [OME5]:** The DSNP EOC model includes a table for SPAP contact information. Is that not applicable here?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Medicare Part D drugs (other than “Extra Help” you still get the 70 percent discount on covered brand name drugs. Also, the plan pays five percent of the cost of brand drugs in the coverage gap. The 70 percent discount and the five percent paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

## H3. **AIDS Drug Assistance Program (ADAP)**

*[Plans should delete this section if not applicable.]* The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance *[insert state-specific ADAP information.]* Note: to be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of the State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance For information on eligibility criteria, covered drugs, or how to enroll in the program, please call *[insert state-specific ADAP contact information.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## I. Social Security

Social Security determines eligibility and handles enrollment for Medicare. U.S. Citizens and lawful permanent residents who are 65 and older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

**Commented [OME6]:** The DSNP EOC model includes a "How to contact the Railroad Retirement Board" and "Do you have "group insurance" or other health insurance from an employer?", do these sections not apply to integrated plans?

|                |                                                                                                                                                                                                                                  |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | 1-800-772-1213<br>Calls to this number are free.<br>Available 8:00 am to 7:00 pm, Monday through Friday.<br>You can use their automated telephone services to get recorded information and conduct some business 24 hours a day. |
| <b>TTY</b>     | 1-800-325-0778<br>This number is for people who difficulty with hearing or speaking. You must have special telephone equipment to call it.                                                                                       |
| <b>WRITE</b>   | <Insert Mailing address>                                                                                                                                                                                                         |
| <b>EMAIL</b>   | <i>[Email address is optional.]</i><br><a href="mailto:">mailto:</a>                                                                                                                                                             |
| <b>WEBSITE</b> | <a href="http://www.ssa.gov">www.ssa.gov</a>                                                                                                                                                                                     |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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## J. Other resources

*[Plans may insert this section to provide additional information resources, such as county aging and disability resource centers, choice counselors, or area agencies on aging or any other sections as directed by the state. Plans should format consistently with other sections, include a brief description and information about any other resources they add, and update the Table of Contents.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Chapter 4: Benefits chart

### Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services *[insert if the plan has cost sharing: and how much you pay for each service]*. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

### Table of Contents

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**If you have questions**, please call <plan name> at <toll-free phone and TTY/TDD numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 1

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## A. Your covered services *[insert if the plan has cost sharing: and your out-of-pocket costs]*

This chapter tells you about services our plan covers *[insert if the plan has cost-sharing: and how much you pay for each service]*. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your *Member Handbook*. *[Insert if applicable: This chapter also explains limits on some services.]*

*[Plans with cost sharing, insert: For some services, are charged an out-of-pocket cost called a copay. This is a fixed amount (for example, \$5) you pay each time you get that service. You pay the copay at the time you get the medical service.]*

*[Plans with **no** cost-sharing for any services described in this chapter, insert: Because you get assistance from *[Insert name of state-specific Medicaid program]*, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of your *Member Handbook* for details about the plan's rules.]*

If you need help understanding what services are covered, call *[insert: your care coordinator and/or Member Services at <phone number(s)>]*.

*[As applicable, plans insert the subsection heading and information below.]*

### A1. During public health emergencies

*[Plans providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describe the coverage and flexibilities here or include general information about the coverage and flexibilities along with any cross references, as applicable. Plans include whether such coverage and flexibilities are contingent upon the duration of the public health emergency, which may or may not last for the entire year. Plans also include any specific contact information, as applicable, where members can get more details.]*

---

## B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

**You should never get a bill from a provider for covered services.** If you do, refer to **Chapter 7** of your *Member Handbook* or call Member Services.

---

## C. About our plan's Benefits Chart



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans may add references to long-term care or home and community-based services.]*

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them. *[Plans that include an index at the end of the chapter should insert: To find a service in the chart, you can also use the index at the end of the chapter.]*

**We pay for the services listed in the Benefits Chart when the following rules are met.**

*[Plans that do not have cost-sharing, insert: You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.]*

- We provide covered Medicare and *[Insert name of state-specific Medicaid program]* covered services according to the rules set by Medicare and *[Insert name of state-specific Medicaid program]*.
- The services *[Plans may revise as applicable: (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs)]* must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise and use the state-specific definition of “medically necessary” and ensure that it is updated and used consistently in Chapter 12 and throughout member materials.]*
- *[Insert if applicable: You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your *Member Handbook* has more information about using network and out-of-network providers.]*
- *[Insert if applicable: You have a primary care provider (PCP) or a care team that is providing and managing your care. [Plans that do not require referrals, omit the rest of this paragraph:] In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan’s network. This is called a referral. **Chapter 3** of your *Member Handbook* has more information about getting a referral and when you do **not** need one.]*
- *[Insert if applicable: We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need prior authorization (PA) [insert as appropriate: with an asterisk (\*) or with a*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

footnote **or** in bold type *or* in italic type].] *[Insert if applicable: In addition, you must get prior authorization (PA) for the following services not listed in the Benefits Chart: [insert list].]*

- *[Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI)” in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Members with Certain Chronic Conditions**. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [insert if applicable: and/or reduced cost sharing]:*
  - *[List all applicable chronic conditions here.]*
  - *[If offering SSBCI, include information about the process and/or criteria for determining eligibility for SSBCI. Plan must also deliver a written summary of the SSBCI offered to each chronically ill member eligible for SSBCI.]*

Refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.]

- *[Insert as applicable: Most **or** All]* preventive services are free. You find this apple  next to preventive services in the Benefits Chart.
- *[Insert any additional applicable Medicaid program coverage here such as community supports]*

*[Instructions on completing the Benefits Chart:*

- *For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.*
- *Optional supplemental benefits are not permitted in this chart; optional supplemental benefits should be described in section E.*
- *Include the following where appropriate: Talk to your provider and get a referral.*
- *Plans must include any services provided in excess of the Medicare and Medicaid requirements and identify preventive services with the apple icon.*
- *HMO POS plan types must provide information about which services must be obtained from network providers, which services can be obtained out-of-network under the POS benefit, and any differences in cost sharing for covered services obtained out-of-network under the POS benefit.*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Plans should clearly indicate which benefits are subject to prior authorization (PA). (This can be done with asterisks, footnotes, bold type, or italic type. Plans must select only one method of indication, describe it in terms easily understandable by members, make the indication and description prominently visible, and use it consistently throughout the document.)*
- *Plans may insert any additional benefit information that is based on the plan's approved benefit package and not already included in the Benefits Chart or in the exclusions section. Plans insert any additional benefits in the chart alphabetically.*
- *Plans must add any Medicaid benefits covered to the chart as instructed by the state. Insert any additional benefits in the chart alphabetically. If directed by the state, include all non-waiver services in the chart and all HCBS waiver services as a separate section after the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed. The remainder of the sections should then be renumbered.*
- *Plans must describe any restrictive policies, limitations, or monetary limits that might affect a member's access to services within the chart.*
- *Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.*
- *Plans should include all non-waiver LTSS in the chart in alphabetical order.*
- *Plans with no cost sharing for any type of service (i.e., no cost sharing at all) may delete the "what you must pay" column from the table. Plans with any type of cost sharing for services, including for pharmacy services, must leave the "what you must pay" column in the table.*
- *Plans offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:*
  - *Deliver to each clinically-targeted member a written summary of those benefits so that such member are notified of the "Uniformity Flexibility" benefits for which they are eligible.*
  - *Update the Benefits Chart to include details, as applicable, about the exact targeted reduced cost sharing amount for each specific service and/or the additional supplemental benefits being offered.]*



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D. Our plan’s Benefits Chart

[When a benefit continues from one page to the next, plans enter a blank return before right aligning and inserting at the bottom of the first part of the description: **This benefit is continued on the next page.** At the top of the next page where the benefit description continues, plans enter the benefit name again in bold followed by (continued). Plans may refer to **Durable medical equipment (DME) and related supplies** and other benefits later in this chart as examples. Plans should also be aware that the flow of benefits from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed.]

[Plans should modify this section throughout to reflect Medicaid or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medicaid.]

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                          | What you must pay                                        |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
|  | <p><b>Abdominal aortic aneurysm screening</b></p> <p>We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p> <p>[List any additional benefits offered.]</p> | <p>\$0</p> <p>[List copays for additional benefits.]</p> |

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | What you must pay                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|
|  <b>Acupuncture</b><br>We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: <ul style="list-style-type: none"><li>• lasting 12 weeks or longer;</li><li>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);</li><li>• not associated with surgery; <b>and</b></li><li>• not associated with pregnancy.</li></ul> In addition, we pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.<br>Acupuncture treatments must be stopped if you don't get better or if you get worse.<br><a href="#">[List any additional benefits offered.]</a> |  | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |
|  <b>Alcohol misuse screening and counseling</b><br>We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.<br>If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.<br><a href="#">[List any additional benefits offered.]</a>                                                                                                                                                                                                                                                                                                             |  | \$0                                                               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | What you must pay                                                 |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
|    | <b>Ambulance services</b><br><br>Covered ambulance services include ground, air (airplane and helicopter), and rotary-wing ambulance services. The ambulance will take you to the nearest place that can give you care.<br><br>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases must be approved by us.<br><br>In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. | \$0                                                               |
|  | <b>Annual wellness visit</b><br><br>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                                                                                                                                                                                                                                                  | \$0                                                               |
|  | <b>Bone mass measurement</b><br><br>We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.<br><br>We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.<br><br><a href="#">[List any additional benefits offered.]</a>                                                                                                                            | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
|  <p><b>Breast cancer screening (mammograms)</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>One baseline mammogram between the ages of 35 and 39 <i>[plans that only cover ages 65 and older should delete]</i></li> <li>One screening mammogram every 12 months <i>[plans that cover women under 65 should include: for women age 40 and older]</i></li> <li>Clinical breast exams once every 24 months</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                    | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><b>Cardiac (heart) rehabilitation services</b></p> <p>We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's <i>[insert as appropriate: referral or order]</i>.</p> <p>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.</p>                                                                                                                                                                                                                                              | <p>\$0</p>                                                      |
|  <p><b>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</b></p> <p>We pay for one visit a year, or more if medically necessary, with your primary care provider to help lower your risk for heart disease. During the <i>[insert: visit or visits]</i>, your doctor may:</p> <ul style="list-style-type: none"> <li>Discuss aspirin use,</li> <li>Check your blood pressure, <b>and/or</b></li> <li>Give you tips to make sure you are eating well.</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | What you must pay                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
|  <b>Cardiovascular (heart) disease testing</b><br>We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                         | \$0<br><i>[List copays for additional benefits.]</i>                     |
|  <b>Cervical and vaginal cancer screening</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>For all women: Pap tests and pelvic exams once every 24 months</li> <li>For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months</li> <li><i>[Plans that cover women under 65 must include: For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months]</i></li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><i>[List copays for additional benefits.]</i>                     |
| <b>Chiropractic services</b><br>We pay for the following services: <ul style="list-style-type: none"> <li>Adjustments of the spine to correct alignment</li> </ul> <i>[List any Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.]</i>                                                                                                                                                                                                                                                                                                                         | <i>[List copays.]</i><br><i>[List copays for supplemental benefits.]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
|  <b>Colorectal cancer screening</b><br>For people 50 and older, we pay for the following services: <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema) every 48 months</li> <li>• Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months</li> <li>• DNA based colorectal screening, every 3 years</li> <li>• Screening Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy)</li> <li>• Screening Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months.</li> </ul> <i>[List any additional benefits offered.]</i> | \$0<br><br><i>[List copays for additional benefits.]</i>                        |
| <i>[Include row if applicable and modify to accurately describe the Medicaid and/or supplemental benefit offered.]</i><br><b>Dental services</b><br>Certain dental services, including cleanings, fillings, and dentures, are available through the <i>[insert name of Medicaid program or integrated name]</i> Dental Program.<br><i>[Plans that offer optional supplemental dental benefits insert: Note: Our plan offers additional dental services. Got to Benefits Chart in Section E for more information.]</i>                                                                                                                                                                                                                                 | <i>[If plan offers supplemental benefit, the maximum copay amount is \$10.]</i> |
|  <b>Depression screening</b><br>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.<br><i>[List any additional benefits offered.]</i>                                                                                                                                                                                                                                                                                                                                                                                                                             | \$0<br><br><i>[List copays for additional benefits.]</i>                        |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <div data-bbox="154 464 191 499"></div> <p><b>Diabetes screening</b></p> <p>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"> <li>• High blood pressure (hypertension)</li> <li>• History of abnormal cholesterol and triglyceride levels (dyslipidemia)</li> <li>• Obesity</li> <li>• History of high blood sugar (glucose)</li> </ul> <p>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.</p> <p>Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.</p> <p><a href="#">[List any additional benefits offered.]</a></p> | <p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| <div data-bbox="154 464 191 506"></div> <div data-bbox="207 470 824 501"><b>Diabetic self-management training, services, and supplies</b></div> <div data-bbox="207 518 773 575"><p>We pay for the following services for all people who have diabetes (whether they use insulin or not):</p></div> <div data-bbox="215 588 799 1218"><ul style="list-style-type: none"><li>• Supplies to monitor your blood glucose, including the following:<ul style="list-style-type: none"><li>○ A blood glucose monitor</li><li>○ Blood glucose test strips</li><li>○ Lancet devices and lancets</li><li>○ Glucose-control solutions for checking the accuracy of test strips and monitors</li></ul></li><li>• For people with diabetes who have severe diabetic foot disease, we pay for the following:<ul style="list-style-type: none"><li>○ One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, <b>or</b></li><li>○ One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)</li></ul></li><li>• In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.</li></ul></div> <div data-bbox="207 1232 568 1260"><p><a href="#">[List any additional benefits offered.]</a></p></div> | <div data-bbox="876 470 914 497">\$0</div> <div data-bbox="876 512 1076 569"><p><a href="#">[List copays for additional benefits.]</a></p></div> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Durable medical equipment (DME) and related supplies</b></p> <p>Refer to Chapter 12 of your <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).”</p> <p>We cover the following items:</p> <ul style="list-style-type: none"> <li>• Wheelchairs</li> <li>• Crutches</li> <li>• Powered mattress systems</li> <li>• Diabetic supplies</li> <li>• Hospital beds ordered by a provider for use in the home</li> <li>• Intravenous (IV) infusion pumps and pole</li> <li>• Speech generating devices</li> <li>• Oxygen equipment and supplies</li> <li>• Nebulizers</li> <li>• Walkers</li> <li>• Standard curved handle or quad cane and replacement supplies</li> <li>• Cervical traction (over the door)</li> <li>• Bone stimulator</li> <li>• Dialysis care equipment</li> </ul> <p>Other items may be covered.</p> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays, including how they vary for equipment covered by Medicare and Medicaid, if applicable.]</i></p> <p><i>[Include if applicable: Your cost sharing for Medicare oxygen equipment coverage is [insert copay amount or coinsurance percentage], every [insert required frequency of payment].]</i></p> <p><i>[Plans that use a constant cost-sharing structure for oxygen equipment insert: Your cost sharing will not change after being enrolled for 36 months.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | What you must pay                                                                                                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Durable medical equipment (DME) and related supplies (continued)</b></p> <p><i>[Plans that do not limit the DME brands and manufacturers that they cover, insert: We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.]</i></p> <p><i>[Plans that limit the DME brands and manufacturers that they cover, insert the following (for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual): With this Member Handbook, we sent you our plan's list of DME. The list tells you the brands and makers of DME that we pay for. You may also find the most recent list of brands, makers, and suppliers on our website at &lt;URL&gt;.</i></p> <p>Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We do not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to our plan and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)</p> <p>If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor may file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is right for your medical condition. For more information about appeals, refer to <b>Chapter 9</b> of your <i>Member Handbook</i>.]</p> | <p><i>[Plans that wish to vary cost sharing for oxygen equipment after 36 months insert details including whether original cost sharing resumes after 5 years and you are still in the plan.] [If cost sharing is different for members who made 36 months of rental payments prior to joining the plan insert: If prior to enrolling in [insert plan name] is [insert cost sharing].]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Emergency care</b></p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> <li>Given by a provider trained to give emergency services, <b>and</b></li> <li>Needed to treat a medical emergency.</li> </ul> <p>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> <li>Serious risk to your health <i>[Plans that cover women under 65 must include: or to that of your unborn child]; or</i></li> <li>Serious harm to bodily functions; <b>or</b></li> <li>Serious dysfunction of any bodily organ or part; <b>or</b></li> <li><i>[Plans that cover women under 65 must include: In the case of a pregnant woman in active labor, when:</i> <ul style="list-style-type: none"> <li>There is not enough time to safely transfer you to another hospital before delivery.</li> <li>A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]</li> </ul> </li> </ul> <p><i>[Also identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.]</i></p> | <p>\$0</p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, <i>[plans should insert information as needed to accurately describe emergency care benefits: (e.g., you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.)]</i>.</p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| <p data-bbox="212 474 805 527"><i>[If family planning services are covered, plans should modify this as necessary.]</i></p> <p data-bbox="212 541 477 569"><b>Family planning services</b></p> <p data-bbox="212 590 776 674">The law lets you choose any provider for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p data-bbox="212 688 542 716">We pay for the following services:</p> <ul data-bbox="212 730 821 1297" style="list-style-type: none"> <li>• Family planning exam and medical treatment</li> <li>• Family planning lab and diagnostic tests</li> <li>• Family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring)</li> <li>• Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)</li> <li>• Counseling and diagnosis of infertility and related services</li> <li>• Counseling, testing, and treatment for sexually transmitted infections (STIs)</li> <li>• Counseling and testing for HIV and AIDS, and other HIV-related conditions</li> <li>• Permanent Contraception (You must be age 21 or older to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.)</li> <li>• Genetic counseling</li> </ul> <p data-bbox="212 1312 813 1396">We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:</p> <ul data-bbox="212 1411 821 1545" style="list-style-type: none"> <li>• Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)</li> <li>• Treatment for AIDS and other HIV-related conditions</li> <li>• Genetic testing</li> </ul> | <p data-bbox="885 474 1013 501"><i>[List copays.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
|  <b>Health and wellness education programs</b><br><i>[These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness and stress management. Describe the nature of the programs here.]</i><br><i>[If this benefit is not applicable, plans should delete this row.]</i>                                                                                                                                                                                                             | <i>[List copays.]</i>                                                  |
| <i>[Plans should modify this section to reflect plan-covered benefits as appropriate.]</i><br><b>Hearing services</b><br>We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.                                                                                                                                                                                                                                                                                                                                                                | <i>[List copays.]</i><br><i>[List copays for additional benefits.]</i> |
| <i>[If this benefit is not applicable, plans should delete this row.]</i><br><b>Help with certain chronic conditions</b><br><i>[Plans that offer targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI),” which members with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits and (as applicable) reduced cost sharing. If offering SSBCI, plans must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package submission.]</i> | <i>[List copays.]</i>                                                  |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
|  <b>HIV screening</b><br>We pay for one HIV screening exam every 12 months for people who: <ul style="list-style-type: none"> <li>• Ask for an HIV screening test, <b>or</b></li> <li>• Are at increased risk for HIV infection.</li> </ul> For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.<br><a href="#">[List any additional benefits offered.]</a>                                                                                                                                                                                                                                                                                                                                                                                                                                    | \$0<br><a href="#">[List copays for additional benefits.]</a> |
| <b>Home health agency care</b><br><a href="#">[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</a><br>Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort.<br>We pay for the following services, and maybe other services not listed here: <ul style="list-style-type: none"> <li>• 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.)</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> </ul> | <a href="#">[List copays.]</a>                                |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                                                                   |
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| <p><b>Home infusion therapy</b></p> <p>Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:</p> <ul style="list-style-type: none"><li>• The drug or biological substance, such as an antiviral or immune globulin;</li><li>• Equipment, such as a pump; <b>and</b></li><li>• Supplies, such as tubing or a catheter.</li></ul> <p>Our plan covers home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"><li>• Professional services, including nursing services, provided in accordance with your care plan;</li><li>• Member training and education not already included in the DME benefit;</li><li>• Remote monitoring; <b>and</b></li><li>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.</li></ul> <p><a href="#">[List any additional benefits offered.]</a></p> | <p><a href="#">[List copays.]</a></p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                                                                                    |
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| <p><b>Hospice care</b></p> <p>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Our plan pays for the following while you get hospice services:</p> <ul style="list-style-type: none"> <li>• Drugs to treat symptoms and pain</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul> <p><b>Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.</b></p> <ul style="list-style-type: none"> <li>• Refer to <b>Section F</b> of this chapter for more information.</li> </ul> <p><b>For services covered by our plan but not covered by Medicare Part A or Medicare Part B:</b></p> <ul style="list-style-type: none"> <li>• Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay <i>[insert as appropriate: our plan's cost-sharing amount or nothing]</i> for these services.</li> </ul> <p><b>For drugs that may be covered by our plan's Medicare Part D benefit:</b></p> <ul style="list-style-type: none"> <li>• Drugs are never covered by both hospice and our plan at the same time. For more information, refer to <b>Chapter 5</b> of your <i>Member Handbook</i>.</li> </ul> <p><b>Note:</b> If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that is <b>not</b> related to your terminal prognosis.</p> <p><i>[Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.]</i></p> | <p><i>[List copays.]</i></p> <p><i>[Include information about cost sharing for hospice consultation services if applicable.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay                                                        |
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| <div data-bbox="154 464 191 499"></div> <p><b>Immunizations</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine</li> <li>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary</li> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B</li> <li>• COVID-19 vaccines</li> <li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li> </ul> <p>We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to <b>Chapter 6</b> of your <i>Member Handbook</i> to learn more.</p> <p><a href="#">[List any additional benefits offered.]</a></p> | <p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                                                                                                                    |
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| <p><b>Inpatient hospital care</b></p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p><i>[List any restrictions that apply.]</i></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units, such as intensive care or coronary care units</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Needed surgical and medical supplies</li> <li>• Appliances, such as wheelchairs</li> <li>• Operating and recovery room services</li> <li>• Physical, occupational, and speech therapy</li> <li>• Inpatient substance abuse services</li> <li>• In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><b>\$0</b></p> <p>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.</p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay |
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| <p><b>Inpatient hospital care (continued)</b></p> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. <i>[Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.]</i></p> <ul style="list-style-type: none"> <li>• Blood, including storage and administration</li> <li>• Physician services</li> </ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are you a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> |                   |
| <p><b>Inpatient services in a psychiatric hospital</b></p> <p>We pay for mental health care services that require a hospital stay. <i>[List days covered, restrictions such as 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.]</i></p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay |
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| <p><i>[Plans with no day limitations on a plan's hospital or nursing facility coverage may modify or delete this row as appropriate.]</i></p> <p><b>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</b></p> <p>We do not pay for your inpatient stay if it is not reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Doctor services</li> <li>• Diagnostic tests, like lab tests</li> <li>• X-ray, radium, and isotope therapy, including technician materials and services</li> <li>• Surgical dressings</li> <li>• Splints, casts, and other devices used for fractures and dislocations</li> <li>• Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: <ul style="list-style-type: none"> <li>○ An internal body organ (including contiguous tissue), <b>or</b></li> <li>○ The function of an inoperative or malfunctioning internal body organ.</li> </ul> </li> <li>• Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition</li> <li>• Physical therapy, speech therapy, and occupational therapy</li> </ul> | <p>\$0</p>        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | What you must pay |
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| <p><b>Kidney disease services and supplies</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services.</li><li>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in <b>Chapter 3</b> of your <i>Member Handbook</i>, or when your provider for this service is temporarily unavailable or inaccessible.</li><li>• Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care</li><li>• Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments</li><li>• Home dialysis equipment and supplies</li><li>• Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply.</li></ul> <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.</p> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay                                               |
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|  <p><b>Lung cancer screening</b></p> <p>Our plan pays for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> <li>• Are aged 50-77, <b>and</b></li> <li>• Have a counseling and shared decision-making visit with your doctor or other qualified provider, <b>and</b></li> <li>• Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.</li> </ul> <p>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.</p> <p><i>[Modify section to accurately describe benefits and list any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                           | <p>\$0</p>                                                      |
|  <p><b>Medical nutrition therapy</b></p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when <i>[insert as appropriate: referred or ordered]</i> by your doctor.</p> <p>We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.</p> <p>We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's <i>[insert as appropriate: referral or order]</i>. A doctor must prescribe these services and renew the <i>[insert as appropriate: referral or order]</i> each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | What you must pay |
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|  <b>Medicare Diabetes Prevention Program (MDPP)</b><br>Our plans pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: <ul style="list-style-type: none"> <li>• Long-term dietary change, <b>and</b></li> <li>• Increased physical activity, <b>and</b></li> <li>• Ways to maintain weight loss and a healthy lifestyle.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$0               |
| <b>Medicare Part B prescription drugs</b><br><i>[Plans that do or expect to use Medicare Part B step therapy should indicate the Medicare Part B drug categories below that are or may be subject to Medicare Part B step therapy as well as a link to a list of drugs subject to Medicare Part B step therapy. Plans may update the link throughout the year and add any changes at least 30 days prior to implementation per 42 CFR 422.111(d).]</i><br>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: <ul style="list-style-type: none"> <li>• Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <li>• Osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What you must pay |
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| <p><b>Medicare Part B prescription drugs (continued)</b></p> <ul style="list-style-type: none"> <li>Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents <i>[plans may delete any of the following drugs that they do not not cover]</i> (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</li> <li>IV immune globulin for the home treatment of primary immune deficiency diseases</li> </ul> <p><i>[Insert if applicable: The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: &lt;hyperlink&gt;.]</i></p> <p>We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit.</p> <p><b>Chapter 5</b> of your <i>Member Handbook</i> explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p><b>Chapter 6</b> of your <i>Member Handbook</i> explains what you pay for your outpatient prescription drugs through our plan.</p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay            |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate or eliminate this section if not covered.]</i></p> <p><b>Nursing facility care</b></p> <p>A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital.</p> <p>Services that we pay for include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Nursing services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Respiratory therapy</li> <li>• Drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)</li> <li>• Blood, including storage and administration</li> <li>• Medical and surgical supplies usually given by nursing facilities</li> <li>• Lab tests usually given by nursing facilities</li> <li>• X-rays and other radiology services usually given by nursing facilities</li> <li>• Use of appliances, such as wheelchairs usually given by nursing facilities</li> <li>• Physician/practitioner services</li> <li>• Durable medical equipment</li> <li>• Dental services, including dentures</li> <li>• Vision benefits</li> </ul> <p><b>This benefit is continued on the next page</b></p> | <p><i>[List copays.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | What you must pay                                               |
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| <p><b>Nursing facility care (continued)</b></p> <ul style="list-style-type: none"> <li>• Hearing exams</li> <li>• Chiropractic care</li> <li>• Podiatry services</li> </ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> <li>• A nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care).</li> <li>• A nursing facility where your spouse or domestic partner is living at the time you leave the hospital.</li> </ul> |                                                                 |
| <p> <b>Obesity screening and therapy to keep weight down</b></p> <p>If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                         | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
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| <p><b>Opioid treatment program (OTP) services</b></p> <p>Our plan pays for the following services to treat opioid use disorder (OUD):</p> <ul style="list-style-type: none"> <li>• Intake activities</li> <li>• Periodic assessments</li> <li>• Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications</li> <li>• Substance use counseling</li> <li>• Individual and group therapy</li> <li>• Testing for drugs or chemicals in your body (toxicology testing)</li> </ul> <p><i>[List any other medically necessary treatment or additional benefits offered, with the exception of meals and transportation.]</i></p> | \$0               |
| <p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy, including technician materials and supplies</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts, and other devices used for fractures and dislocations</li> <li>• Lab tests</li> <li>• Blood, including storage and administration</li> <li>• Other outpatient diagnostic tests</li> </ul> <p><i>[Plans can include other covered tests as appropriate.]</i></p>                   | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay                                               |
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| <p><b>Outpatient hospital services</b></p> <p>We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"><li>• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services<ul style="list-style-type: none"><li>○ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.”</li><li>○ Sometimes you can be in the hospital overnight and still be “outpatient.”</li><li>○ You can get more information about being inpatient or outpatient in this fact sheet: <a href="http://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a></li></ul></li><li>• Labs and diagnostic tests billed by the hospital</li><li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it</li><li>• X-rays and other radiology services billed by the hospital</li><li>• Medical supplies, such as splints and casts</li><li>• Preventive screenings and services listed throughout the Benefits Chart</li><li>• Some drugs that you can’t give yourself</li></ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay                                               |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient mental health care</b></p> <p>We pay for mental health services provided by:</p> <ul style="list-style-type: none"> <li>• A state-licensed psychiatrist or doctor</li> <li>• A clinical psychologist</li> <li>• A clinical social worker</li> <li>• A clinical nurse specialist</li> <li>• A nurse practitioner</li> <li>• A physician assistant</li> <li>• Any other Medicare-qualified mental health care professional as allowed under applicable state laws</li> </ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient rehabilitation services</b></p> <p>We pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p>                                                                                                                                                                                                       | <p>\$0</p>                                                      |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay            |
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| <p><b>Outpatient substance abuse services</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• Alcohol misuse screening and counseling</li> <li>• Treatment of drug abuse</li> <li>• Group or individual counseling by a qualified clinician</li> <li>• Subacute detoxification in a residential addiction program</li> <li>• Alcohol and/or drug services in an intensive outpatient treatment center</li> <li>• Extended-release Naltrexone (vivitrol) treatment</li> </ul> <p><i>[Modify this list accurately describe benefits offered or add any additional benefits offered.]</i></p>                                                                                        | <p><i>[List copays.]</i></p> |
| <p><b>Outpatient surgery</b></p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p>                   |
| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Partial hospitalization services</b></p> <p>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.</p> <p><i>[Network plans that do not have an in-network community mental health center may add: <b>Note:</b> Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.]</i></p> | <p>\$0</p>                   |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | What you must pay                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <p><b>Physician/provider services, including doctor's office visits</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"><li>• Medically necessary health care or surgery services given in places such as:</li><li>• Physician's office</li><li>• Certified ambulatory surgical center</li><li>• Hospital outpatient department</li><li>• Consultation, diagnosis, and treatment by a specialist</li><li>• Basic hearing and balance exams given by your <i>[insert as applicable: primary care provider or specialist]</i>, if your doctor orders them to find out whether you need treatment</li><li>• <i>[Insert if providing any additional telehealth benefits consistent with 42 CFR § 422.135 in the plan's approved Plan Benefit Package submission: Certain telehealth services, including [insert general description of covered additional telehealth benefits (i.e., the specific Medicare Part B service(s) the plan has identified as clinically appropriate for offering through electronic exchange when the provider is not in the same location as the member). Plans may refer members to their medical coverage policy here].]</i></li></ul> <p><b>This benefit is continued on the next page</b></p> | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"><li>○ 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. <i>[Plans may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.]</i></li><li>○ <i>[List the available means of electronic exchange used for each Medicare Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.]</i></li><li>● <i>[Insert if the plan's service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act: Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare]</i></li><li>● Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home</li><li>● Telehealth services to diagnose, evaluate, or treat symptoms of a stroke</li><li>● Telehealth services for members with a substance use disorder or co-occurring mental health disorder</li></ul> <p><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | What you must pay |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> <li>○ You have an in-person visit within 6 months prior to your first telehealth visit</li> <li>○ You have an in-person visit every 12 months while receiving these telehealth services</li> <li>○ Exceptions can be made to the above for certain circumstances</li> </ul> </li> <li>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.</li> <li>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b> <ul style="list-style-type: none"> <li>○ you're not a new patient <b>and</b></li> <li>○ The check-in isn't related to an office visit in the past 7 days and</li> <li>○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> <li>• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours <b>if</b>: <ul style="list-style-type: none"> <li>○ you're not a new patient and</li> <li>○ The evaluation isn't related to an office visit in the past 7 days <b>and</b></li> <li>○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p> |                   |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What you must pay                                               |
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| <p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient</li> <li>• Second opinion <i>[insert if appropriate: by another network provider]</i> before surgery</li> <li>• Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> <li>○ Surgery of the jaw or related structures</li> <li>○ Setting fractures of the jaw or facial bones</li> <li>○ Pulling teeth before radiation treatments of neoplastic cancer</li> <li>○ Services that would be covered when provided by a physician</li> </ul> </li> </ul> <p><i>[List any additional benefits offered.]</i></p> |                                                                 |
| <p><b>Podiatry services</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)</li> <li>• Routine foot care for members with conditions affecting the legs, such as diabetes</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |
| <p> <b>Prostate cancer screening exams</b></p> <p><i>[Plans that cover men under age 65 must include: For men age 50 and older,]</i> we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> <li>• A digital rectal exam</li> <li>• A prostate specific antigen (PSA) test</li> </ul> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                              | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | What you must pay                                               |
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| <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Prosthetic devices and related supplies</b></p> <p>Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> <li>• Colostomy bags and supplies related to colostomy care</li> <li>• Pacemakers</li> <li>• Braces</li> <li>• Prosthetic shoes</li> <li>• Artificial arms and legs</li> <li>• Breast prostheses (including a surgical brassiere after a mastectomy)</li> </ul> <p>We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.</p> <p><i>[Plans that pay for prosthetic dental devices, delete the following sentence:]</i> We will not pay for prosthetic dental devices.</p> | <p>\$0</p>                                                      |
| <p><b>Pulmonary rehabilitation services</b></p> <p>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have <i>[insert as appropriate: a referral or an order]</i> for pulmonary rehabilitation from the doctor or provider treating the COPD.</p> <p><i>[List any additional benefits offered.]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>\$0</p> <p><i>[List copays for additional benefits.]</i></p> |



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay                                                 |
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|  <b>Sexually transmitted infections (STIs) screening and counseling</b><br><br>We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered <a href="#">[plans that cover women under age 65 should include: for pregnant women and]</a> for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.<br><br>We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.<br><br><a href="#">[Also list any additional benefits offered.]</a> | \$0<br><br><a href="#">[List copays for additional benefits.]</a> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | What you must pay |
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| <p><b>Skilled nursing facility (SNF) care</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"><li>• A semi-private room, or a private room if it is medically necessary</li><li>• Meals, including special diets</li><li>• Nursing services</li><li>• Physical therapy, occupational therapy, and speech therapy</li><li>• Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors</li><li>• Blood, including storage and administration</li><li>• Medical and surgical supplies given by nursing facilities</li><li>• Lab tests given by nursing facilities</li><li>• X-rays and other radiology services given by nursing facilities</li><li>• Appliances, such as wheelchairs, usually given by nursing facilities</li><li>• Physician/provider services</li></ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"><li>• A nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)</li><li>• A nursing facility where your spouse or domestic partner lives at the time you leave the hospital</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay                                                 |
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|  | <p><b>Smoking and tobacco use cessation</b></p> <p>If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit:</p> <ul style="list-style-type: none"><li>• We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.</li></ul> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</p> <ul style="list-style-type: none"><li>• We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</li></ul> <p><i>[List any additional benefits offered.]</i></p> | <p>\$0</p> <p><i>[List copays for supplemental benefits.]</i></p> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay |
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| <p><b>Supervised exercise therapy (SET)</b></p> <p>We pay for SET for members with symptomatic peripheral artery disease (PAD) <i>[insert if applicable: who have a referral for PAD from the physician responsible for PAD treatment]</i>.</p> <p>Our plan pays for:</p> <ul style="list-style-type: none"><li>• Up to 36 sessions during a 12-week period if all SET requirements are met</li><li>• An additional 36 sessions over time if deemed medically necessary by a health care provider</li></ul> <p>The SET program must be:</p> <ul style="list-style-type: none"><li>• 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)</li><li>• In a hospital outpatient setting or in a physician's office</li><li>• Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD</li><li>• Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques</li></ul> | \$0               |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
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| <p><b>Urgently needed care</b></p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"> <li>• A non-emergency that requires immediate medical care, <b>or</b></li> <li>• A sudden medical illness, <b>or</b></li> <li>• An injury, <b>or</b></li> <li>• A condition that needs care right away.</li> </ul> <p>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or during the weekend).</p> <p><i>[Include in-network benefits. Also identify whether this coverage is within the U.S. and its territories or is supplemental world-wide emergency/urgent coverage.]</i></p> | <p>\$0</p>        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | What you must pay                                                          |
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|  <i>[Plans should modify this section to reflect Medicaid and plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]</i><br><b>Vision care</b><br><br>We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.<br><br>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: <ul style="list-style-type: none"><li>• People with a family history of glaucoma</li><li>• People with diabetes</li><li>• African-Americans <i>[plans that cover under 65 must include: who are age 50 and older]</i></li><li>• Hispanic Americans <i>[plans that cover under 65 must include: who are 65 or older]</i></li></ul> <i>[Plans should modify this description if the plan offers more than is covered by Medicare.]</i> We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.<br><br>If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery. | <i>[List copays.]</i><br><br><i>[List copays for additional benefits.]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Services that our plan pays for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | What you must pay |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
|  <p><b>“Welcome to Medicare” preventive visit</b></p> <p>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> <li>• A review of your health,</li> <li>• Education and counseling about the preventive services you need (including screenings and shots), <b>and</b></li> <li>• Referrals for other care if you need it.</li> </ul> <p><b>Note:</b> We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.</p> | \$0               |

## E. Extra “Optional Supplemental” benefits you can buy

*[Include this section if you offer optional supplemental benefits in the plan and describe benefits below. Plans must explain how these benefits are different than what is covered under Medicaid and must indicate if any of the optional supplemental benefits are covered by Medicaid. You may include this section either in the Member Handbook or as an insert to the Member Handbook.]*

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package. These extra benefits are called “**Optional Supplemental Benefits**.” If you want these optional supplemental benefits, you must sign up for them *[insert if applicable: and you may have to pay an additional premium for them.]* The optional supplemental benefits described in *[insert as applicable: this section OR the enclosed insert]* are subject to the same appeals process as any other benefits.

*[Insert plan specific optional supplemental benefits, premiums, deductible, copays, and coinsurance and rules using a chart like the Benefits Chart above. Insert plan specific procedures on how to elect optional supplemental coverage, including application process and effective dates and on how to discontinue optional supplemental coverage, including refund of premiums. Also, insert any restrictions on members’ re-applying for optional supplemental coverage (e.g., must wait until next annual enrollment period).]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



## F. Our plan's visitor or traveler benefits

*[If your plan offers a visitor/traveler program to members who are out of your service area, insert this section, adapting and expanding the following paragraphs as needed to describe the traveler benefits and rules related to getting the out-of-area coverage. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR §422.74(b)(4)(iii) (for more than 6 months up to 12 months), also explain that here based on the language suggested below:]*

If you are out of the plan's service area for more than 6 months at a time but do not permanently move, we usually must disenroll you from our plan. However, we offer a visitor/traveler program *[specify areas where the visitor/traveler program is being offered]* that allows you to remain enrolled in our plan when you are outside of our service area for up to 12 months. Under our visitor/traveler program, you get all plan-covered services at in-network cost-sharing prices. Contact us for help in finding a provider when you use the visitor/traveler benefit.

If you are in a visitor/traveler area, you can stay enrolled in the plan until <end date>. If you don't return to our plan's service area by <end date>, we will end your membership in our plan.]

## G. Benefits covered outside of our plan

*[Plans should modify this section to include additional benefits covered outside the plan by Medicaid fee-for-service and/or a Medicaid managed care plan, as appropriate.]*

We don't cover the following services, but they are available through Medicare or *[insert name state-specific name of Medicaid program]*.

### G1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

#### **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis**

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

#### **For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

#### For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook*.

**Note:** If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care not related to your terminal prognosis.

**Commented [OME1]:** The content here seems to be similar to the content written in the benefits chart. Would it be possible to combine this with the language in the benefits chart?

## H. Benefits not covered by our plan, Medicare, or *[insert name of state-specific Medicaid program]*.

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medicaid do not for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan does not cover the following items and services:

*[The services listed in the remaining bullets are excluded from Medicare's and Medicaid's benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Medicaid or have become covered due to a Medicare or Medicaid change in coverage policy, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans may add parenthetical references to the Benefits Chart for descriptions of covered services and items as appropriate. Plans may also add exclusions as needed.]*

- Services considered not "reasonable and medically necessary," according to Medicare and *[insert name state-specific name of Medicaid program]* standards, unless we list these as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Refer to **Chapter 3** of your *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it.
- A private room in a hospital, except when medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- *[Plans should delete this if the state allows:]* Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines.
- Routine foot care, except as described in Podiatry services in the Benefits Chart in Section D.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- *[Plans delete this if supplemental:]* Regular hearing exams, hearing aids, or exams to fit hearing aids.
- *[Plans delete this if supplemental:]* Radial keratotomy, LASIK surgery, and other low-vision aids.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. [\[Zero cost-sharing plans may adjust this language as applicable\]](#) However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

# Chapter 7: Asking us to pay *[plans with cost sharing, insert: our share of]* a bill you got for covered services or drugs

## Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans with an arrangement with the State may add language to reflect that the organization is not allowed to reimburse members for Medicaid-covered benefits. Plans may not revise the chapter or section headings except as indicated.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Asking us to pay for your services or drugs

[Plans with cost sharing delete the next sentence.] You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We do not allow <plan name> providers to bill you for these services [insert as applicable: or drugs]. We pay our providers directly, and we protect you from any charges.

**If you get a bill for [plans with cost sharing insert: the full cost of] health care or drugs, do not pay the bill and send the bill to us.** To send us a bill, refer to [plans may insert reference, as applicable].

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid [plans with cost sharing, insert: more than your share of the cost; plans with no cost sharing, insert: the bill], it is your right to be paid back.
  - If you paid for services covered by Medicare, we will pay you back.
  - If you paid for services covered by [insert name of state-specific Medicaid program] we can't pay you back, but the provider will. Member services or [insert the term for your care coordinator] can help you contact the provider's office. Refer to the bottom of the page for the member services phone number.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services [insert if appropriate: or your care coordinator] if you have any questions. If [plans with cost sharing insert: you do not know what you should have paid, or if] you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

### 1. When you get emergency or urgently needed health care from an out-of-network provider

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back [plans with cost sharing insert: for our share of the cost]. Send us the bill and proof of any payment you made.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - If the provider should be paid, we will pay the provider directly.
  - If you already paid *[plans with cost sharing insert: more than your share of the cost]* for the Medicare service, we will *[plans with cost sharing insert: figure out how much you owed and]* pay you back *[plans with cost sharing insert: for our share of the cost]*.

## 2. When a network provider sends you a bill

Network providers must always bill us, it's important to show your plan ID card when you get any services or prescriptions. But sometimes they make mistakes, and ask you to pay for your services or more than your share of the costs. **Call Member Services** *[insert if appropriate: or your care coordinator]* at the number at the bottom of this page **if you get any bills.**

- *[Plans with no cost sharing, insert: Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.]*
- *[Plans with cost sharing, insert: As a plan member, you only pay the copay when you get services we cover. We don't allow providers to bill you more than this amount. This is true even if we pay the provider less than the provider charged for a service. Even if we decide not to pay for some charges, you still do not pay them.]*
- Whenever you get a bill from a network provider *[plans with cost sharing insert: that you think is more than you should pay]*, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, *[plans with cost sharing insert: but you feel that you paid too much,]* send us the bill and proof of any payment you made. We will pay you back *[insert as appropriate: for your covered services or for the difference between the amount you paid and the amount you owed under our plan]*.

## 3. If you are retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Send us the bill and proof of any payment you made.

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, will we cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back *[plans with cost sharing insert: for our share of the cost]*.
- Refer to **Chapter 5** of your *Member Handbook* to learn more about out-of-network pharmacies.

#### 5. When you pay the full *[insert if only applicable to Medicare Part D: Medicare Part D]* prescription cost because you don't have your plan ID card with you

If you don't have your plan ID card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your plan ID card.
- Send us a copy of your receipt when you ask us to pay you back *[plans with cost sharing insert: for our share of the cost]*.

#### 6. When you pay the full *[insert if only applicable to Medicare Part D: Medicare Part D]* prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Member Handbook*).
  - If you and your doctor or other prescriber think you need the drug right away, (within 72 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your *Member Handbook*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for *[plans with cost sharing insert: our share of the cost of]* the drug.

**Commented [OME1]:** The DSNP EOC model includes the following instruction: *[Plans should insert additional circumstances under which they will accept a paper claim from a member.]*

Does this not apply to integrated plans?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide the service or drug should be covered, we pay for *[insert if the plan has cost sharing: our share of the cost of]* it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your *Member Handbook*.

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## B. Sending us a request for payment

*[Plans may edit this section to include a second address if they use different addresses for processing health care and drug claims.]*

*[Plans may edit this section as necessary to describe their claims process.]*

Send us your bill and proof of any payment you made for Medicare services *[Insert if allowed: or call us]*. Proof of payment can be a copy of the check you wrote or a receipt from the provider.

**It’s a good idea to make a copy of your bill and receipts for your records.** *[Plans with care coordinators who can assist, insert: You can ask your care coordinator for help.] [Insert if applicable: You must send your information to us within [insert timeframe] of the date you received the service, item, or drug.]*

*[If the plan has a specific form for requesting payment, insert the following language: To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.]*

- You aren’t required to use the form, but it helps us process the information faster.
- You can get the form on our website (<web address>), or you can call Member Services and ask for the form.]

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

*[Insert address.]*

*[If the plan allows members to submit oral payment requests, insert the following language:*

*You may also call us to ask payment.] [Plans include all applicable numbers and days and hours of operation.]*

*[Insert if applicable: You must submit your claim to us within <number of days> days of the date you got the service, item, or drug.]*

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## C. Coverage decisions



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug.** We also decide the amount of money, if any, you must pay.

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay *[plans with cost sharing insert: our share of the cost]* for it. If you already paid for the service or drug, we will mail you a check for *[insert as applicable: what you paid or our share of the cost]*. If you haven't paid, we will pay the provider directly.

**Chapter 3** of your *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of your *Member Handbook* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for *[plans with cost sharing insert: our share of the cost of]* the service or drug, we will send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9 *[insert reference, as applicable]*.

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## D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making an appeal." You can also make an appeal if you don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of your *Member Handbook*: *[plans may insert reference, as applicable]*.

- To make an appeal about getting paid back for a health care service, refer to **Section F** *[insert reference, as applicable]*.
- To make an appeal about getting paid back for a drug, refer to **Section G** *[insert reference, as applicable]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

# Chapter 8: Your rights and responsibilities

## Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Note: Plans may add to or revise this chapter as needed to reflect NCQA required language or language required by state Medicaid program.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Your right to get services and information in a way that meets your needs

*[Plans may edit the section heading and content to reflect the types of alternate format materials available to plan members. Plans may not edit references to language except as noted below.]*

*[Plans must insert a translation of this section in all languages that meet the language threshold.]*

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call *[insert if applicable: your care coordinator or]* Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials *[insert if required to provide materials in any non-English languages: in languages other than English and]* in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call or write to *[Insert Plan name, address, and phone number]*. *[Plans specifically state which languages are offered. Plans also simply describe:*
  - *how they request a member's preferred language other than English and/or alternate format,*
  - *how they keep the member's information as a standing request for future mailings and communications so the member doesn't need to make a separate request each time, and*
  - *how a member can change a standing request for preferred language and/or format.]*

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- *[Plans should insert information about filing a complaint with Medicaid. Also, include any other state-required offices.]*
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B. Our responsibility for your timely access to covered services and drugs

[Plans may edit this section to add specific requirements for **minimum access to care** and remedies.]

Commented [OME1]: Please clarify what minimum access to care means?

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Member Handbook*.
  - Call [insert if applicable: your care coordinator or] Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- [Plans may edit this sentence to add other types of providers that members may use without a referral.] Women have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that is not your PCP. [If applicable, replace the previous sentences with: We do not require you to get referrals. or We do not require you to use network providers.]
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Member Handbook*.
- [Plans should include any additional state requirements regarding covered services or drugs here.]



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. For more information, visit <web address>.

**Chapter 9** of your *Member Handbook* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

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## C. Our responsibility to protect your personal health information (PHI)

We protect your personal health information (PHI) as required by federal and state laws.

Your PHI includes information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights to when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

### C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws. *[Plans may insert similar information, as appropriate, about sharing medical records with Medicaid]*

### C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. *[Insert if applicable: We may charge you a fee for making a copy of your medical records.]*
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you have questions or concerns about the privacy of your PHI, call Member Services.

*[Plans may insert custom privacy practices.]*

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## D. Our responsibility to give you information

*[Plans may edit the section to reflect the types of alternate format materials available to plan members and/or languages primarily spoken in the plan's service area.]*

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call us at <phone number>. This is a free service to you. *[Plans must insert information about the availability of written materials in languages other than English, stating specifically which languages are offered.]* We can also give you information in large print, braille, or audio. *[If applicable, plans insert information about the availability of written materials in other formats.]*

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of your *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Member Handbook*) covered by our plan
  - limits to your coverage and drugs



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Member Handbook*), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

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## E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of your *Member Handbook*.

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## F. Your right to leave our plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another MA plan.
- Refer to **Chapter 10** of your *Member Handbook*:
  - For more information about when you can join a new MA or prescription drug benefit plan.
  - For information about how you will get your [\[Insert name of Medicaid program\]](#) benefits if you leave our plan.

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## G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

### G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Member Handbook* tells how to ask us for a coverage decision.

## **G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself**

*[Note: Plans that would like to provide members with state-specific information about advance directives may do so. Include contact information for the appropriate state agency.]*

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you.**
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do **not** want.

The legal document that you use to give your directions is called an “advance directive.” There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You are not required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. *[Insert if applicable: You can also contact Member Services to ask for the form.]*
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- *[Insert any additional state-specific requirements as directed by the state.]*

Call Member Services for more information.

### G3. What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with *[plans insert the name and contact information of the applicable state-specific agency]*.

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## H. Your right to make complaints and ask us to reconsider our decisions

**Chapter 9** of your *Member Handbook* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

### H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it is **not** about discrimination for reasons listed in **Chapter 11** of your *Member Handbook* – or you want more information about your rights, you can call:

- Member Services at *<insert phone and TTY numbers>*.
- The *[insert name of state-specific SHIP]* program at *[insert phone number]*. For more details about *[insert name of state-specific SHIP]*, refer to Chapter 2 *[insert reference, as applicable]*.
- *[Insert this section if applicable: The Ombudsman Program at <phone number>. For more details about this program, refer to Chapter 2 of your Member Handbook.]*

**Commented [OME2]:** Please confirm what "if applicable" means here. Should this bullet be included if there is an Ombudsmen designated for this service area.

Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at [www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf](http://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf).)

*[If applicable, plans should insert additional contact information, such as for the state Medicaid agency.]*

**Commented [OME3]:** Please clarify. Why wouldn't plans list their respective state agency here?

## I. Your responsibilities as a plan member

*[Plans may modify this section to include additional member responsibilities. Plans may add information about estate recovery and other requirements mandated by the state.]*

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your *Member Handbook*. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your plan ID card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- *[Plans should edit the bullets below as needed to reflect the costs applicable to their members.]* **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most *<plan name>* members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.
  - *[Delete this bullet if the plan does not have cost sharing:]* For some of your *[insert if the plan has cost sharing for long-term services and supports: long-term services and supports [or drugs]]* covered by the plan, you must pay your share of the cost when you get the *[insert if the plan has cost sharing for services: service [or drug]]*. This will be a *[insert as appropriate: [copayment/copay] (a fixed amount) or coinsurance (a percentage of the total cost)]*. *[Insert if the plan has cost sharing for long-term services and supports: Chapter 4 [plans may insert reference, as applicable] tells what you must pay for your long-term services and supports.] Chapter 6 [plans may insert reference, as applicable] tells what you must pay for your drugs.*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (Note: If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to Chapter 9 [plans may insert reference, as applicable] to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call [insert if applicable: your care coordinator or] Member Services.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Member Handbook* tells about our service area.
  - We can help you find out if you're moving outside our service area. [Plans that do not offer plans outside the service area may delete the following sentence:] During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and [Insert state-specific name of Medicaid program] your new address when you move. Refer to **Chapter 2** of your *Member Handbook* for phone numbers for Medicare and [Insert name of state-specific Medicaid program].
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Call [insert if applicable: your care coordinator or] Member Services for help if you have questions or concerns.**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

*[Plans that integrate the description of Medicare and Medicaid processes must revise the sections of this chapter as needed to clearly describe the appeals and grievance processes.]*

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[In cases where members should contact a department other than Member Services (for example, a grievance and appeals unit), plans should revise the instructions to provide the appropriate contact information.]*

### Introduction

This chapter has information about your rights. Read this chapter to find out what to do if: [\[Add any additional language for state-specific Medicaid information\]](#)

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

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**Commented [OME1]:** UnitedHealthcare (UHC) recommends remaining consistent with the current models as creating a whole new format and content creates risk in developing the documents and increases time required to manage additional templates.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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## A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints**; also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

### A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” instead of “Independent Review Entity”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

---

## B. Where to get help

### B1. For more information and help

Sometimes it's confusing to start or follow the process for dealing with a problem. This can be especially true if you don't feel well or have limited energy. Other times, you may not have the information you need to take the next step.

**Help from the** *[Insert state-specific name of the SHIP program]*

You can call the *[insert state-specific name of the SHIP program]*. *[insert state-specific name of the SHIP program]* counselors can answer your questions and help you understand what to do about your problem. *[Insert state-specific name of the SHIP program]* is not connected with us or with any insurance company or health plan. *[Insert state-specific name of the SHIP program]* has trained counselors in every county, and services are free. The *[insert state-specific name of the SHIP program]* phone number is *[insert phone number]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)).

### Help and information from *[insert name of state-specific Medicaid program]*

*[Insert contact information for the state Medicaid agency. Insert similar sections for the QIO or ombudsman, as applicable.]*

---

## C. Understanding Medicare and *[insert name of state-specific Medicaid program]* complaints and appeals in our plan

You have Medicare and *[insert name of state-specific Medicaid program]*. Information in this chapter applies to **all** of your Medicare and *[insert name of state-specific Medicaid program]* benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and *[insert state-specific name of Medicaid program]* processes.

Sometimes Medicare and *[insert state-specific name of Medicaid program]* processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a *[insert state-specific name of Medicaid program]* benefit. **Section F4** explains these situations.

---

## D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The chart below helps you find the right section of this chapter for problems or complaints.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Is your problem or concern about your benefits or coverage?**

This includes problems about whether particular medical care or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs.

**Yes.**

My problem is about  
benefits or coverage.

Refer to **Section E**, "Coverage decisions  
and appeals."

**No.**

My problem is not about  
benefits or coverage.

Refer to **Section K**, "How to make a  
complaint."

**E. Coverage decisions and appeals**

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

**E1. Coverage decisions**

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. We make a coverage decision whenever we decide what is covered for you and how much we pay. For example, your network doctor makes a favorable coverage decision for you whenever you get medical care from them or if they refer you to a medical specialist.

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or [\[insert state-specific name of Medicaid program\]](#). If you disagree with this coverage decision, you can make an appeal.

**E2. Appeals**

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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 if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter *[insert reference, as applicable]*, you can ask for an expedited or “fast coverage decision” or *[fast appeal of a coverage decision]*.

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare medical service or item or Part B drugs, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about *[Level 2 Appeals]*.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

### E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- *[Insert name of SHIP program and contact information.]*
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

*[Insert any additional state-specific references for assistance with coverage decisions and appeals as applicable.]*

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the “Appointment of Representative” form. You can also get the form by visiting [www.cms.gov/Medicare/CMS-](http://www.cms.gov/Medicare/CMS-)

**Commented [OME2]:** Please confirm, should expedited and fast appeal be in quotation marks?

**Commented [OME3]:** Suggest adding the following language as the last sentence as many services are covered by both Medicare and Medicaid - “If your problem is about a coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 appeals.”



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

[Forms/CMS-Forms/downloads/cms1696.pdf](#) *[plans may also insert: or on our website at <web address or link to form>]. You must give us a copy of the signed form.*

#### E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, “Medical care” *[insert reference, as applicable]*
- **Section G**, “Medicare Part D prescription drugs” *[insert reference, as applicable]*
- **Section H**, “Asking us to cover a longer hospital stay” *[insert reference, as applicable]*
- **Section I**, “Asking us to continue covering certain medical services” *[insert reference, as applicable]* (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you’re not sure which section to use, call Member Services at the numbers at the bottom of the page. *[Plans may insert additional resources and contact information (e.g., SHIP, Ombudsman Program).]*

---

### F. Medical care

*[Plans may update the heading and terms such as “medical care” throughout to account for Medicaid services such as behavioral health and long-term care services as directed by the state.]*

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for *[insert if plan has cost sharing: our share of the cost of]* your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of your *Member Handbook*. We generally refer to “medical care coverage” or “medical care” in the rest of this section. The term “medical care” includes medical services and items as well as Medicare Part B prescription drugs which are drugs administered by your doctor or health care professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

#### F1. Using this section

This section explains what you can do in any of the five following situations:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

1. You think we cover medical care you need but are not getting.

**What you can do:** You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

**What you can do:** You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we will not pay.

**What you can do:** You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

**What you can do:** You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

**What you can do:** You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

- If the coverage is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Refer to **Section H** *[insert reference, as applicable]* or **Section I** *[insert reference, as applicable]* to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

## F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **"integrated organization determination."**

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: *<phone number>* TTY: *<phone number>*.
- Faxing: *<phone number>*.
- Writing: *<address>*.

### Standard coverage decision



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

When we give you our decision, we use the “standard” deadlines unless we agree to use the “fast” deadlines. A standard coverage decision means we give you an answer about a:

- Medical service or item within 14 calendar days after we get your request. *[Plan may adjust timeframe if state has more restrictive requirement as directed by the state.]*
- Medicare Part B prescription drug within 72 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can’t take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a “fast complaint” about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, Refer to **Section K** *[insert reference, as applicable]*.

#### Fast coverage decision

The legal term for “fast coverage decision” is “**expedited determination**.”

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a “fast coverage decision.” A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can’t take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a “fast complaint” about our decision to take extra days. For more information about making a complaint, including a fast complaint, Refer to **Section K** *[insert reference, as applicable]*. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- You are asking for coverage for medical care you **did not get**. You can't ask for a fast coverage decision about payment for medical care you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

**We automatically give you a fast coverage decision if your doctor tells us your health requires it.** If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K** *[insert reference, as applicable]*.

**If we say No to part or all of your request**, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3** *[insert reference, as applicable]*).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- If the request is incomplete,
- If someone makes the request on your behalf but isn't legally authorized to do so, or
- If you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

### **F3. Making a Level 1 Appeal**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**To start an appeal**, you, your doctor, or your representative must contact us. Call us at *<phone number>* *[insert additional contact information, as applicable]*.

**Ask for a standard appeal or a fast appeal** in writing or by calling us at *<phone number>*.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, *[insert as applicable: you may need to name them as your representative to act on your behalf.]*
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) *[plans may also insert: or on our website at <web address> or link to form>]*.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

The legal term for "fast appeal" is "**expedited reconsideration.**"

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.

**Commented [OME4]:** AIP plans require appointment of representative in this scenario. Suggest removing "insert as applicable."

**Commented [OME5]:** Under the Part D section, these 3 paragraphs are bulleted. Should they be bulleted here?



**If you have questions**, please call *<plan name>* at *<toll-free phone and TTY numbers>*, *<days and hours of operation>*. The call is free. **For more information**, visit *<web address>*.

- The process for a fast appeal is the same as for a fast coverage decision. To ask for a fast appeal, follow the instructions for asking for a fast coverage decision in **Section F2** *[insert reference, as applicable]*.
- If your doctor tells us that your health requires it, we will give you a fast appeal.

**If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.**

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.
  - If you do not appeal before these dates, then your service or medication will not be continued while you wait for your appeal decision.

**We consider your appeal and give you our answer.**

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

**There are deadlines for a fast appeal.**

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.

**Commented [OME6]:** There is no guarantee that a member requesting an expedited appeal will receive one.

While the second bullet states the process for a fast appeal is the same as for a fast coverage decision, UHC believes it would be more member friendly to include similar language as coverage decision.

**We automatically give you a fast appeal if your doctor tells us your health requires it.** If you ask without your doctor's support, we decide if you get a fast appeal. If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:

- We automatically give you a fast appeal if your doctor asks for it.

- How you can file a "fast complaint" about our decision to give you a standard appeal decision instead of a fast appeal decision. For more information about making a complaint, including a fast complaint, refer to **Section K** *[insert reference, as applicable]*.

**Commented [OME7]:** Suggest replacing "medication" with "item" to be consistent with previous bullets.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
- If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage if a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In <insert name of state> a Fair Hearing is called <insert description>.]*
- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request**, we send your appeal to the Independent Review Organization for a Level 2 Appeal.

**There are deadlines for a standard appeal.**

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If you think we should **not** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage if a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In <insert name of state> a Fair Hearing is called <insert description>.]*

If we say **Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights**:

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the Independent Review Organization for a Level 2 Appeal.
- If your problem is about coverage of a *[insert name of state-specific Medicaid program]* service or item, the letter tells you how to file a Level 2 Appeal yourself.

#### F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, *[insert name of state-specific Medicaid program]*, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that *[insert name of state-specific Medicaid program]* usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter *[insert reference, as applicable]*.
- If your problem is about a service or item that **both Medicare and** *[insert name of state-specific Medicaid program]* may cover, you automatically get a Level 2 Appeal with the Independent Review Organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** *[insert reference, as applicable]* for information about continuing your benefits during Level 1 Appeals.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the Independent Review Organization.
- If your problem is about a service that usually covered only by [\[insert state-specific name of Medicaid program\]](#), your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

#### **When your problem is about a service or item Medicare usually covers**

The Independent Review Organization reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**," sometimes called the "**IRE**."

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the Independent Review Organization, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization take a careful look at all information related to your appeal.

#### **If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.**

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The Independent Review Organization must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

#### **If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.**

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- 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 getting your appeal.
- If your request is for a Medicare Part B prescription drug, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

The Independent Review Organization gives you their answer in writing and explains the reasons.

- **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 Independent Review Organization's decision for **standard requests or**
  - Provide the service **within 72 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- **If the Independent Review Organization says Yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Medicare Part B prescription drug under dispute:
  - **Within 72 hours** after we get the Independent Review Organization's decision for **standard requests or**
  - **Within 24 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- **If the Independent Review Organization says No to part or all of your appeal**, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- There are three additional levels in the appeals process after Level 2, for a total of five levels.
- If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
- An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** *[insert reference, as applicable]* for more information about Level 3, 4, and 5 Appeals.

**When your problem is about a service or item Medicaid usually covers, or that is covered by both Medicare and *[insert name of state-specific Medicaid program]***

A Level 2 Appeal for services that *[insert name of state-specific Medicaid program]* usually covers is a Fair Hearing with the state. In *<insert name of state>* a Fair Hearing is called *<insert description>*. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

*[Plans should describe the process for Medicaid Level 2 Appeals, in which members must submit the Level 2 Appeal themselves.]*

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the Independent Review Organization or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **Independent Review Organization**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the Independent Review Organization explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



Refer to **Section J** *[insert reference, as applicable]* for more information about your appeal rights after Level 2.

## F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. *[Plans with cost sharing insert: The only amount you should be asked to pay is the copay for [insert service, item, and/or drug categories that require a copay].]*

*[Plans insert if the state DOES NOT allow members to be directly reimbursed for Medicaid benefits: We can't reimburse you directly for a Medicaid service or item. If you get a bill [plans with cost sharing insert: that is more than your copay] for Medicaid covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.]*

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to Chapter 7 of your Member Handbook.]

*[Plans insert if the state DOES allow members to be directly reimbursed for Medicaid benefits: If you get a bill [plans with cost sharing insert: that is more than your copay] for covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.]*

*For more information, refer to Chapter 7 of your Member Handbook. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.*

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.]

- If the service or item you paid for is covered and you followed all the rules, we will send *[insert: you or your provider]* *[insert: the payment or if the plan has cost sharing, our share of the cost]* for the service or item within 60 calendar days after we get your request. *[Insert, as applicable: Your provider will then send the payment to you.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3** *[insert reference, as applicable]*. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the Independent Review Organization. We will send you a letter if this happens.

- If the Independent Review Organization reverses our decision and says we should pay you, we must send the payment to you or to the provider 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 to you or to the health care provider within 60 calendar days.
- If the Independent Review Organization says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and *[insert name of Medicaid program]* usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information. *[Plans may edit as needed and/or provide additional instructions about the process for Level 2 payment appeals.]*

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## G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that *[insert name of state-specific Medicaid program]* may cover. **This section only applies to**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Medicare Part D drug appeals.** We'll say "drug" in the rest of this section. Instead of saying "Medicare Part D drug" every time. *[Insert as applicable and adjust language as directed by the state: For drugs covered only by Medicaid follow the process in Section E on page <insert page number>.]*

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Member Handbook* for more information about a medically accepted indication.

### G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - Cover a Medicare Part D drug that is not on our plan's Drug List or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

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

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

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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 make an appeal. Use the chart below to help you.

| Which of these situations are you in?                                                                             |                                                                                                                                                              |                                                                               |                                                                             |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.     | You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need. | You want to ask us to pay you back for a drug you already got and paid for.   | We told you that we won't cover or pay for a drug in the way that you want. |
| <b>You can ask us to make an exception.</b> (This is a type of coverage decision.)                                | <b>You can ask us for a coverage decision.</b>                                                                                                               | <b>You can ask us to pay you back.</b> (This is a type of coverage decision.) | <b>You can make an appeal.</b> (This means you ask us to reconsider.)       |
| Start with <b>Section G2</b> , then refer to <b>Sections G3 and G4</b> <i>[insert reference, as applicable]</i> . | Refer to <b>Section G4</b> <i>[insert reference, as applicable]</i> .                                                                                        | Refer to <b>Section G4</b> <i>[insert reference, as applicable]</i> .         | Refer to <b>Section G5</b> <i>[insert reference, as applicable]</i> .       |

**G2. Medicare Part D exceptions**

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

**1. Covering a drug that is not on our Drug List**

- *[Plans without cost sharing delete]* If we agree to make an exception and cover a drug that is not on our Drug List, you pay the copay that applies *[insert as appropriate: to all of our drugs or drugs in [insert exceptions tier] or drugs in [insert exceptions tier] for brand name drugs or [insert exceptions tier] for generic drugs]*.
- You can't get an exception to the required copay amount for the drug.

## 2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Member Handbook* for more information).
  - Extra rules and restrictions for certain drugs include:
    - *[Omit if the plan does not use generic substitution]* Being required to use the generic version of a drug instead of the brand name drug.
    - *[Omit if the plan does not use prior authorization (PA)]* Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
    - *[Omit if the plan does not use step therapy]* Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
    - *[Omit if the plan does not use quantity limits]* Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
  - *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit this bullet.]* If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.
3. *[Plans with no cost sharing and plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions, omit this section.]* **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of *[insert number of tiers]* cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

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

- Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
  - *[Plans that have a formulary structure where all biological products are on one tier or that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.
  - *[Plans that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
  - *[Plans that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.
- *[If the plan designated one of its tiers as a “specialty tier” and exempts that tier from the exceptions process, include the following language: You can’t ask us to change the cost-sharing tier for any drug in [insert tier number and name of tier designated as the high-cost/unique drug tier].]*
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can’t take, you usually pay the lowest amount.

### G3. Important things to know about asking for an exception

#### Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for 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 often includes more than one drug for treating a specific condition. These are called “alternative” drugs. If an alternative drug is just as effective as the drug you ask for and wouldn’t cause more side effects or other health problems, we generally do **not** approve your exception request. *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit the next sentence.]* If you ask us for a tiering exception, we generally do **not** approve your exception request unless all 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 you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar 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 exception request, you can make an appeal. Refer to **Section G5** *[insert reference, as applicable]* for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

#### **G4. Asking for a coverage decision, including an exception**

- Ask for the type of coverage decision you want by calling <phone number>, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** *[insert reference, as applicable]* to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.
- *[Plans that allow members to submit coverage determination requests electronically (e.g., through a secure member portal) may include a brief description of that process.]*

#### **If your health requires it, ask us for a "fast coverage decision."**

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

- You can get a fast coverage decision if:
- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K** [\[insert reference, as applicable\]](#).

#### Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization. Refer to **Section G6** [\[insert reference, as applicable\]](#) for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



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

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

#### Deadlines for a standard coverage decision about 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 send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

### G5. Making a Level 1 Appeal

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

- Start your **standard** or **fast appeal** by calling <phone number>, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your **claim**.
- You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you

**Commented [OME8]:** Suggest changing this to "appeal".



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

had a serious illness or we gave you the wrong information about the deadline.  
Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal.  
You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

A fast appeal is also called an “**expedited redetermination.**”

- If you appeal a decision we made about a drug you didn’t get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** *[insert reference, as applicable]* for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1**

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
- We give you our answer sooner if your health requires it.
  - If we don’t give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** *[insert reference, as applicable]* for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

**Deadlines for a standard appeal at Level 1**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** [\[insert reference, as applicable\]](#) for information about the review organization and the Level 2 appeals process.

**Commented [OME9]:** Should these bullets be submit bullets to bullet 1?

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** [\[insert reference, as applicable\]](#) for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

## G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **Independent Review Organization** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

The formal name for the “Independent Review Organization” is the “**Independent Review Entity**,” sometimes called the “**IRE**.”

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the Independent Review Organization **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you **include instructions about how to make a Level 2 Appeal** with the Independent Review Organization. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the Independent Review Organization, we send the information we have about your appeal to the organization. This information is called your “case file.” **You have the right to a free copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

**Commented [OME10]:** Grammatical correction: Should be “includes”.

The Independent Review Organization reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** *[insert reference, as applicable]* for more information about the Independent Review Organization.

#### **Deadlines for a fast appeal at Level 2**

If your health requires it, ask the Independent Review Organization for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the Independent Review Organization’s decision.

#### **Deadlines for a standard appeal at Level 2**

If you have a standard appeal at Level 2, the Independent Review Organization must give you an answer:

- **Within 7 calendar days** after they get your appeal for a drug you didn’t get.
- **Within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the Independent Review Organization says **Yes** to part or all of your request:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We must provide the approved drug coverage **within 72 hours** after we get the Independent Review Organization's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the Independent Review Organization's decision.
  - If the Independent Review Organization says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the Independent Review Organization says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The Independent Review Organization sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the Independent Review Organization says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the Independent Review Organization sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Member Handbook*.

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

## H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Call Medicare at 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit [www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices).

## H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In [\[insert name of state\]](#), the Quality Improvement Organization is [\[insert state-specific QIO name\]](#). Call them at [\[insert QIO toll-free phone number\]](#). Contact information is also in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**.

**Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date.**

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the Quality Improvement Organization’s decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, appeal to our plan directly instead. Refer to **Section G4** [\[insert reference, as applicable\]](#) for information about making an appeal to us.

**Ask for help if you need it.** If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the [\[insert name of state SHIP including contact information\]](#).

**Ask for a fast review.** Act quickly and contact the Quality Improvement Organization to ask for a fast review of your hospital discharge.

The legal term for “**fast review**” is “**immediate review**” or “**expedited review**.”



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

### What happens during fast review

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the “**Detailed Notice of Discharge.**” You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices).

Within one full day after getting all of the information it needs, the Quality Improvement Organization give you their answer to your appeal.

If the Quality Improvement Organizations says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Improvement Organization says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- 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 their answer to your appeal.
- You can make a Level 2 Appeal if the Quality Improvement Organization turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

### H3. Making a Level 2 Appeal



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at [\[insert QIO toll-free phone number\]](#).

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

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Quality Review Organization says **Yes** to your appeal:

- We must pay you back for [\[plans with cost sharing should include: our share of\]](#) hospital care costs since noon on the day after the date the Quality Improvement Organization turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Review Organization says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

#### H4. Making a Level 1 Alternate Appeal

The deadline for contacting the Quality Improvement Organization for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

The legal term for "fast review" or "fast appeal" is "**expedited appeal**."

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any [\[plans with cost sharing should include: share\]](#) of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of giving saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** [\[insert reference, as applicable\]](#) for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for [\[plans with cost sharing should include: our share of\]](#) the costs of care you got since the date when we said your coverage would end.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- Home health care services
- Skilled nursing care in a skilled nursing facility
- Rehabilitation care as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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.

### I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

### I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** *[insert reference, as applicable]* for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the *[insert state name of SHIP program and contact information]*.
- **Contact the Quality Improvement Organization.**
  - Refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal."** Ask the Quality Improvement Organization if it's medically appropriate for us to end coverage of your medical services.

#### Your deadline for contacting this organization

- 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 we sent you.
- If you miss the deadline for contacting the Quality Improvement Organization, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4** *[insert reference, as applicable]*.

The legal term for the written notice is "**Notice of Medicare Non-Coverage.**" To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or get a copy online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices).

#### What happens during a fast-track appeal



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is “**Detailed Explanation of Non-Coverage.**”

- Reviewers tell you their decision within one full day after getting all the information they need.

If the Independent Review Organization says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

**Commented [OME11]:** This should be changed to Quality Improvement Organization

If the Independent Review Organization says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying *[plans with cost sharing should include: our share of]* the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

**Commented [OME12]:** This should be changed to Quality Improvement Organization

### 13. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at *[insert QIO toll-free phone number]*.

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 continue care after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

**Commented [OME13]:** This should be changed to Quality Improvement Organization

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

**Commented [OME14]:** This should be changed to Quality Improvement Organization

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** *[insert reference, as applicable]* for information about Level 3, 4, and 5 Appeals.

#### **I4. Making a Level 1 Alternate Appeal**

As explained in **Section I2** *[insert reference, as applicable]*, you must act quickly and contact the Quality Improvement Organization to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review.”

The legal term for “fast review” or “fast appeal” is “**expedited appeal**.”

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We agree to pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- If we say **No** to your fast appeal:
- Our coverage for these services ends on the date we told you.
- We will not pay any *[plans with cost sharing should include: share]* of the costs after this date.
- You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### 15. Making a Level 2 Alternate Appeal

During the Level 2 Appeal,

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** *[insert reference, as applicable]* for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your **hospital discharge** and usually give you an answer within 72 hours.

**Commented [OME15]:** Should hospital discharge be replaced with "termination, suspension, or reduction of previously authorized services:"

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for *[plans with cost sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- We will provide your **covered inpatient hospital services** for as long as the services are medically necessary.

**Commented [OME16]:** Should covered inpatient hospital services be replaced with "<termination, suspension, or reduction of previously authorized services:"

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

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## J. Taking your appeal beyond Level 2

### J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the Independent Review Organization for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we 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 service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 reviews your appeal and gives you an answer. The Council is part of the federal government.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

#### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

#### J2. Additional *[insert name of state-specific Medicaid program]* appeals

*You also* have other appeal rights if your appeal is about services or items that *[insert name of state-specific Medicaid program]* usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

*[Plans may, at the discretion of the state, insert a clear, brief description of the procedures, timing, and instructions about what members need to do if they want to file an additional appeal in the state.]*

#### J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

**Commented [OME17]:** Need to insert the word "may" as some states do not have other appeal rights after State Fair Hearing.

You *may* also have other appeal rights if your appeal is about services or items that *[insert name of state-specific Medicaid program]* usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

#### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

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## K. How to make a complaint

### K1. What kinds of problems should be complaints



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If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

| Complaint                                                             | Example                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Quality of your medical care</b>                                   | <ul style="list-style-type: none"> <li>You are unhappy with the quality of care, such as the care you got in the hospital.</li> </ul>                                                                                                                                                                                                                                                                        |
| <b>Respecting your privacy</b>                                        | <ul style="list-style-type: none"> <li>You think that someone did not respect your right to privacy or shared confidential information about you.</li> </ul>                                                                                                                                                                                                                                                 |
| <b>Disrespect, poor customer service, or other negative behaviors</b> | <ul style="list-style-type: none"> <li>A health care provider or staff was rude or disrespectful to you.</li> <li>Our staff treated you poorly.</li> <li>You think you are being pushed out of our plan.</li> </ul>                                                                                                                                                                                          |
| <b>Accessibility and language assistance</b>                          | <ul style="list-style-type: none"> <li>You cannot physically access the health care services and facilities in a doctor or provider's office.</li> <li>Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish).</li> <li>Your provider does not give you other reasonable accommodations you need and ask for.</li> </ul> |
| <b>Waiting times</b>                                                  | <ul style="list-style-type: none"> <li>You have trouble getting an appointment or wait too long to get it.</li> <li>Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.</li> </ul>                                                                                                                                                          |
| <b>Cleanliness</b>                                                    | <ul style="list-style-type: none"> <li>You think the clinic, hospital or doctor's office is not clean.</li> </ul>                                                                                                                                                                                                                                                                                            |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

| Complaint                                           | Example                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Information you get from us                         | <ul style="list-style-type: none"> <li>You think we failed to give you a notice or letter that you should have received.</li> <li>You think written information we sent you is too difficult to understand.</li> </ul>                                                                                                                                                                                                                               |
| Timeliness related to coverage decisions or appeals | <ul style="list-style-type: none"> <li>You think we don't meet our deadlines for making a coverage decision or answering your appeal.</li> <li>You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services.</li> <li>You don't think we sent your case to the Independent Review Organization on time.</li> </ul> |

**There are different kinds of complaints.** You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call [\[insert contacts and contact information\]](#).

The legal term for a “complaint” is a “**grievance.**”

The legal term for “making a complaint” is “**filing a grievance.**”

## K2. Internal complaints

To make an internal complaint, call Member Services at [<phone number>](#). You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *[Insert additional description of the procedures (including time frames) and instructions about what members need to do if they want to use the process for making a complaint, including a fast complaint.]*

**The legal term for “fast complaint” is “expedited grievance.”**

If possible, we 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. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don’t make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don’t agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

### K3. External complaints

#### Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). You do not need to file a complaint with *[insert plan name]* before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

*[Insert additional Medicaid information as required by the state.]*

#### Office for Civil Rights



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

You can make a complaint to the Department of Health and Human Services Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for more information.

You may also contact the local Office for Civil Rights office at:

*[Plans should insert contact information for the OCR regional office.]*

You may also have rights under the Americans with Disability Act and under *[plans may insert relevant state law]*. You can contact *[insert contacts and contact information]*.

### Quality Improvement Organization

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the Quality Improvement Organization.
- You can make your complaint to the Quality Improvement Organization and to our plan. If you make a complaint to the Quality Improvement Organization, we work with them to resolve your complaint.

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. To learn more about the Quality Improvement Organization, refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook*.

In *<state>*, the Quality Improvement Organization is called *<state-specific QIO name>*. The phone number for *<state-specific QIO name>* is *<phone number>*.



**If you have questions**, please call *<plan name>* at *<toll-free phone and TTY numbers>*, *<days and hours of operation>*. The call is free. **For more information**, visit *<web address>*.

## Chapter 12: Definitions of important words

**Commented [OME1]:** There are different definitions used for the same term when comparing the Integrated model to the DSNP model. Can we use the DSNP model definitions for consistency and to alleviate any member confusion?

### Introduction

This chapter includes key terms used throughout your *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*

*[Plans should insert additional definitions not included in this model and exclude model definitions not applicable to your plan, your contractual obligations with CMS or enrolled beneficiaries. Plans should modify definitions as appropriate in the state and/or as directed by the state.]*

*[When plans use key terms in the Member Handbook, they explain the term in the first section where it appears along with a reference to Chapter 12.]*

*[If plans revise terminology (e.g., "Member Services" to "Customer Service," "Care Coordinator" to "Care Manager") that affect glossary terms, plans use the revised term consistently throughout the Member Handbook and alphabetize it in this chapter.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Activities of daily living (ADL):** The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

**Aid paid pending:** You can continue getting your benefits while you are waiting for a decision about a Level 1 Appeal or a State Hearing (Refer to **Chapter 9** of your *Member Handbook* for more information). This continued coverage is called “aid paid pending.”

**Ambulatory surgical center:** A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

**Appeal:** A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your *Member Handbook* explains appeals, including how to make an appeal.

**Behavioral Health:** An all-inclusive term referring to mental health and substance use disorders.

**Brand name drug:** A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

**Care coordinator:** One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

**Care plan:** Refer to “Individualized Care Plan.”

**Care team:** Refer to “Interdisciplinary Care Team.”

*[Plans with a single coverage stage should delete this paragraph.]* **Catastrophic coverage stage:** The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you reach the \$<TrOOP amount> limit for your prescription drugs.

**Centers for Medicare & Medicaid Services (CMS):** The federal agency in charge of Medicare. **Chapter 2** of your *Member Handbook* explains how to contact CMS.

**Complaint:** A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

**Comprehensive outpatient rehabilitation facility (CORF):** A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



*[Plans that do not have copays should delete this paragraph.]* **Copay:** A fixed amount you pay as your share of the cost each time you get certain *[insert if applicable: services or]* prescription drugs. For example, you might pay \$2 or \$5 for *[insert if applicable: a service or]* a prescription drug.

*[Plans that do not have cost sharing should delete this paragraph.]* **Cost sharing:** Amounts you have to pay when you get certain *[insert if applicable: services or]* prescription drugs. Cost sharing includes copays.

*[Plans that do not have cost sharing should delete this paragraph.]* **Cost sharing tier:** A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List) is in one of *[insert number of tiers]* cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

**Coverage decision:** A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your *Member Handbook* explains how to ask us for a coverage decision.

**Covered drugs:** The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

**Covered services:** The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

**Cultural competence training:** Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

*[Plans that do not have cost sharing for Medicare Part D drugs should delete this paragraph. Plans may revise the information in this definition to reflect the appropriate number of days for their one-month supplies as well as the cost-sharing amount in the example.]* **Daily cost sharing rate:** A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost sharing rate is the copay divided by the number of days in a month's supply.

Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment is less than \$0.05 per day multiplied by 7 days, for a total payment less than \$0.35.

**Disenrollment:** The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans that do not have cost sharing add this paragraph.]* **Drug tiers:** Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of *[insert number of tiers]* tiers.

**Dual eligible special needs plan (D-SNP):** Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

**Durable medical equipment (DME):** Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

**Emergency:** A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function *[insert as applicable: (and if you are a pregnant woman, loss of an unborn child)]*. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

**Emergency care:** Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

**Exception:** Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

**Excluded Services:** Services that are not covered by this health plan.

**Extra Help:** Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

**Generic drug:** A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It’s usually cheaper and works just as well as the brand name drug.

**Grievance:** A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

**Health plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

**Health risk assessment:** A review of your medical history and current condition. It’s used to learn about your health and how it might change in the future.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**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 (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

**Hospice:** A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

**Improper/inappropriate billing:** A situation when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. Call Member Services if you get any bills you don't understand.

*[Plans with cost sharing, insert: As a plan member, you only pay our plan's cost sharing amounts when you get services we cover. We do **not** allow providers to bill you more than this amount.]*

*[Plans with no cost sharing, insert: Because we pay the entire cost for your services, you do **not** owe any cost sharing. Providers should not bill you anything for these services.]*

**Individualized Care Plan (ICP or Care Plan):** A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

*[Plans with a single coverage stage delete this paragraph.]* **Initial coverage stage:** The stage before your total Medicare Part D drug expenses reach \$*[insert initial coverage limit]*. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

**Inpatient:** A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

**Interdisciplinary Care Team (ICT or Care team):** A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**List of Covered Drugs (Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary.”

**Long-term services and supports (LTSS):** Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don’t have to go to a nursing facility or hospital. LTSS include Community Based Services and Nursing Facilities (NF).

**Low-income subsidy (LIS):** Refer to “Extra Help.”

*[Insert name of Medicaid program]*: This is the name of *[insert name of state]* Medicaid program. *[Insert name of Medicaid program]* is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

**Commented [OME2]:** During the Washington DC implementation, the District asked us not to use the term “sate.” Is there an opportunity to use an alternative term in this section so that we do not have to version for DC?

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medicaid (or Medical Assistance):** A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

**Medically necessary:** This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise and use the state-specific definition of “medically necessary” and update and use it consistently throughout member materials.]*

**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). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

**Medicare Advantage:** A Medicare program, also known as “Medicare Part C” or “MA,” that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

**Medicare-covered services:** Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part B.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Medicare-Medicaid enrollee:** A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual.”

**Medicare Part A:** The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

**Medicare Part B:** The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

**Medicare Part C:** The Medicare program, also known as “Medicare Advantage” or “MA,” that lets private health insurance companies provide Medicare benefits through an MA Plan.

**Medicare Part D:** The Medicare prescription drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

**Medicare Part D drugs:** Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

**Medication Therapy Management:** A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your *Member Handbook* for more information.

**Member (member of our plan, or plan member):** A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

**Member Handbook and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

**Member Services:** A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Member Handbook* for more information about Member Services.

**Network pharmacy:** A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Network provider:** “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

**Nursing home or facility:** A place that provides care for people who can’t get their care at home but don’t need to be in the hospital.

**Ombudsman:** An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. You can find more information in **Chapters 2 and 9** of your *Member Handbook*.

**Organization determination:** Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions.” **Chapter 9** of your *Member Handbook* explains coverage decisions.

**Original Medicare (traditional Medicare or fee-for-service Medicare):** The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don’t want to be in our plan, you can choose Original Medicare.

**Out-of-network pharmacy:** A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn’t cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

**Out-of-network provider or Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. **Chapter 3** of your *Member Handbook* explains out-of-network providers or facilities.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans that do not have cost sharing delete this paragraph.]* **Out-of-pocket costs:** The cost sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost sharing” above.

**Over-the-counter (OTC) drugs:** Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

**Part A:** Refer to “Medicare Part A.”

**Part B:** Refer to “Medicare Part B.”

**Part C:** Refer to “Medicare Part C.”

**Part D:** Refer to “Medicare Part D.”

**Part D drugs:** Refer to “Medicare Part D drugs.”

**Personal health information (also called Protected health information) (PHI):**

Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

*[Plans that do not use PCPs may omit this paragraph.]* **Primary care provider (PCP):** The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your *Member Handbook* for information about getting care from primary care providers.

**Prior authorization (PA):** *[Plans may delete applicable words or sentences if it does not require PA for any medical services or any drugs.]* An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of your *Member Handbook*.

Our plan covers some drugs only if you get PA from us.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs*.

**Program for All-Inclusive Care for the Elderly (PACE):** A program that covers Medicare and Medicaid benefits together for people age 55 and older who need a higher level of care to live at home.

**Prosthetics and Orthotics:** Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Quality improvement organization (QIO):** A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Member Handbook* for information about the QIO.

**Quantity limits:** A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

**Referral:** A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of your *Member Handbook*.

**Rehabilitation services:** Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Member Handbook* to learn more about rehabilitation services.

**Service area:** A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get our plan.

*[Insert if applicable]* **Share of cost:** The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

**Skilled nursing facility (SNF):** A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

**Skilled nursing facility (SNF) care:** Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

**Specialist:** A doctor who provides health care for a specific disease or part of the body.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



**State Hearing:** If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

**Step therapy:** A coverage rule that requires you to try another drug before we cover the drug you ask for.

**Supplemental Security Income (SSI):** A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently needed care:** Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.



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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Plans may add a back cover for the Member Handbook that contains contact information for Member Services. Below is an example plans may use. Plans also may add a logo and/or photographs, as long as these elements do not make it difficult for members to find and read the contact information.]*

## <Plan name> Member Services

|                |                                                                                                                                                                                                                                                                                             |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CALL</b>    | <i>[Insert phone number(s).]</i><br><br>Calls to this number are free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i><br><br>Member Services also has free language interpreter services available for non-English speakers.    |
| <b>TTY</b>     | <i>[Insert number.]</i><br><br><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]</i><br><br>Calls to this number are free. <i>[Insert days and hours of operation.]</i> |
| <b>FAX</b>     | <i>[Optional: Insert fax number.]</i>                                                                                                                                                                                                                                                       |
| <b>WRITE</b>   | <i>[Insert address.]</i><br><br><i>[Note: Plans may add email addresses here.]</i>                                                                                                                                                                                                          |
| <b>WEBSITE</b> | <i>[Insert URL.]</i>                                                                                                                                                                                                                                                                        |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Instructions to Health Plans

- ❖ *[Plans may include the ANOC in the 2024 Member Handbook (Evidence of Coverage) or provide it to members separately.]*
- ❖ *[Plans may modify the language in the ANOC, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]*
- ❖ *[Plans must use the state-specific name for Medicaid in references to “Medicaid” in any plan-customized language throughout the ANOC.]*
- ❖ *[Throughout the document update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medicaid plans, etc.).]*
- ❖ *[Where the ANOC uses “medical care,” “medical services,” or “health care services” to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]*
- ❖ *[Plans may change references to terms such as “member,” “customer,” “beneficiary,” “enrollee,” “member services,” “care coordinator,” “primary care provider,” “prior authorization (PA)” as instructed by the state or based on plan preference and update them consistently throughout the ANOC.]*
- ❖ *[Where the model material instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]*
- ❖ *[Throughout the ANOC, plans must follow the applicable style rules of the state, if any. For instance, where the model material instructs inclusion of a date or time, plans must use the specific format requested by the state Medicaid program. Other items covered by a state-specific style guide or similar document should also be updated accordingly.]*
- ❖ *[Plans should refer to the Member Handbook as needed using the appropriate chapter number, section, and/or page number. For example, “refer to Chapter 9, Section A, page 1.” An instruction [insert reference, as applicable] appears with many cross references throughout the ANOC and Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*
- ❖ *[Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*

**Commented [OME1]:** Global Comment for proposed integrated ANOC and EOC models: The content layout does not align with the current D-SNP model. UnitedHealthcare (UHC) recommends remaining consistent with the current models as creating a whole new format and content creates risk in developing the documents and increases time required to manage additional templates.

**Commented [PM2]:** this type of state by state variability is where operationally we get stretched



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).*
- *Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.*
- *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
- *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.*
- *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
- *Avoid separating a heading or subheading from the text that follows when paginating the model.*
- *Use universal symbols or commonly understood pictorials.*
- *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
- *Consider using regionally appropriate terms or common dialects in translated models.*
- *Include instructions and navigational aids in translated models in the translated language rather than in English.*
- *Consider producing translated models in large print.]*



<Plan name> [insert plan type] offered by [insert sponsor name]

# Annual Notice of Changes for 2024

[Optional: insert member name]

[Optional: insert member address]

## Introduction

[If there are any changes to the plan for 2024, insert: You are currently enrolled as a member of our plan. Next year, there will be some changes to our [insert as applicable: benefits, coverage, rules, [and] costs]. This [insert as applicable: section or Annual Notice of Changes] tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at [insert URL]. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.]

[If there are no changes whatsoever for 2024 (e.g., no changes to benefits, coverage, rules, costs, networks), insert: You are currently enrolled as a member of our plan. Next year, there are no changes to our benefits, coverage, [and] rules [insert if applicable: and costs]. However, you should still read this [insert as applicable: section or Annual Notice of Changes] to learn about your coverage choices. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at [insert URL]. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.]

[Any plan that does not include a particular section (e.g., Section C, Section F) deletes the section, orders all remaining sections and subsections sequentially, and updates the Table of Contents accordingly. Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## A. Disclaimers

- ❖ *[Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidance and included in any state-specific guidance provided by <insert state>.] [Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, here.]*

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## B. Reviewing your Medicare and *[Insert name of Medicaid program]* coverage for next year

It is important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section E** for more information.

If you choose to leave our plan, your membership will end on the last day of the month in which your request was made. You will still be in the Medicare and *[Insert name of Medicaid program]* programs as long as you are eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section G2** *[insert reference, as applicable]*.
- *[Insert name of Medicaid program]* services in **Section G2** *[insert reference, as applicable]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## B1. Additional resources

- ATTENTION: If you speak *[insert language of the disclaimer]*, language assistance services, free of charge, are available to you. Call *[insert Member Services toll-free phone and TTY numbers, and days and hours of operation]*. The call is free. *[This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation.]*
- You can get this *[Insert as applicable: section or Annual Notice of Changes]* for free in other formats, such as large print, braille, or audio. Call *[insert Member Services toll-free phone and TTY numbers, and days and hours of operation]*. The call is free.
- *[Plans also simply describe:*
  - *how they request a member's preferred language other than English and/or alternate format,*
  - *how they keep the member's information as a standing request for future mailings and communications so the member does not need to make a separate request each time, and*
  - *how a member can change a standing request for preferred language and/or format.]*

## B2. Information about *<plan name>*

- *[Insert plan's legal or marketing name]* is a health plan that contracts with both Medicare and Medicaid to provide benefits of both programs to members.
- Coverage under *[insert plan name]* is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.
- When this *Annual Notice of Changes* says "we," "us," "our," or "our plan," it means *[insert plan name]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



### B3. Important things to do

- **Check if there are any changes to our benefits** *[insert if applicable: and costs]* **that may affect you.**
  - Are there any changes that affect the services you use?
  - Review benefit *[insert if applicable: and cost]* changes to make sure they will work for you next year.
  - Refer to **Section E1** for information about benefit *[insert if applicable: and cost]* changes for our plan.
- **Check if there are any changes to our prescription drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different *[insert if applicable: cost-sharing]* tier? Can you use the same pharmacies?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section E2** for information about changes to our drug coverage.
  - *[All plans with any Medicare Part D cost sharing insert: Your drug costs may have risen since last year.*
    - Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year.
    - Keep in mind that your plan benefits determine exactly how much your own drug costs may change.]
- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section D** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
  - *[Insert if applicable: How much will you spend out-of-pocket for the services and prescription drugs you use regularly?]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- How do the total costs compare to other coverage options?
- **Think about whether you are happy with our plan.**

**If you decide to stay with <2024 plan name>:**

If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in <2024 plan name>.

**If you decide to change plans:**

*[Plans should revise this paragraph as necessary]* If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section G2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

---

**C. Changes to our plan name**

*[Plans that are not changing the plan name, delete this section. Plans with an anticipated name change at a time other than January 1 may modify the date below as necessary.]*

On January 1, 2024, our plan name changes from <2023 plan name> to <2024 plan name>.

*[Insert language to inform members whether they will get new plan ID cards and how, as well as how the name change affects any other member communication.]*

---

**D. Changes to our network providers and pharmacies**

*[Plans with no changes to network providers and pharmacies insert: We have not made any changes to our network of providers and pharmacies for next year.]*

However, it's important that you know that we may make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook*.

*[Plans with changes to provider and/or pharmacy networks, insert: Our [insert if applicable: provider] [and] [insert if applicable: pharmacy] network[s] [insert as applicable: has or have] changed for 2024.]*

Please **review the 2024 Provider and Pharmacy Directory** to find out if your providers or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

website at <web address>. You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook*.]

---

**E. Changes to benefits [insert if applicable: and costs] for next year**

**E1. Changes to benefits [insert if applicable: and costs] for medical services**

[If there are no changes in benefits or in cost sharing, replace the rest of the section with: There are no changes to your benefits [insert if applicable: or amounts you pay] for medical services. Our benefits [insert if applicable: and what you pay for these covered medical services] will be exactly the same in 2024 as they are in 2023.]

We're changing our coverage for certain medical services [insert if applicable: and what you pay for these covered medical services] next year. The table below describes these changes.

[The table must include:

- All new benefits that will be added or 2023 benefits that will end for 2024;
- New or changing limitations or restrictions, including prior authorizations (PA), on benefits for 2024; **and**
- All changes in cost sharing for 2024 for covered medical services, including any changes to service category out-of-pocket maximums.]



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                              | 2023 (this year)                                                                                                                                                                                                                                                                                               | 2024 (next year)                                                                                                                                                                                                                                                                                                  |
|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>[Insert benefit name]</i> | <i>[For benefits that were not covered in 2023, insert:<br/><br/>[insert benefit name] is <b>not</b> covered.]<br/><br/>[For benefits with a copay insert:<br/><br/>You pay a \$&lt;2023 copay amount&gt; copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].]</i> | <i>[For benefits that will not be covered in 2024, insert:<br/><br/>[insert benefit name] is <b>not</b> covered.]<br/><br/>[For benefits with a copay insert:<br/><br/>You pay a \$&lt;2024 copay amount&gt; copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].]</i> |
| <i>[Insert benefit name]</i> | <i>[Insert 2023 cost or coverage, using format described above.]</i>                                                                                                                                                                                                                                           | <i>[Insert 2024 cost or coverage, using format described above.]</i>                                                                                                                                                                                                                                              |

**E2. Changes to prescription drug coverage**

**Changes to our Drug List**

*[Plans that did not include a List of Covered Drugs in the envelope, insert: You will get a 2024 List of Covered Drugs in a separate mailing.]*

*[Plans that did not include a List of Covered Drugs in the envelope and will not mail it separately unless requested, insert: An updated List of Covered Drugs is located on our website at <web address>. You may also call Member Services at the numbers at the bottom of the page for updated drug information or to ask us to mail you a List of Covered Drugs.]*

*[Plans that included a List of Covered Drugs in the envelope, insert: We sent you a copy of our 2024 List of Covered Drugs in this envelope.] The List of Covered Drugs is also called the “Drug List.”*

*[Plans with no changes to covered drugs, tier assignment, or restrictions may replace the rest of this section with: We have not made any changes to our Drug List for next year. However, we are allowed to make changes to the Drug List from time to time throughout the year, with approval from Medicare and/or the state. Refer to the 2024 Drug List for more information.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs.

Review the Drug List to **make sure your drugs will be covered next year** and to find out if there are any restrictions.

If you are affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
  - You can call Member Services at the numbers at the bottom of the page [\[insert if applicable: or contact your care coordinator\]](#) to ask for a list of covered drugs that treat the same condition.
  - This list can help your provider find a covered drug that might work for you.
- [\[Plans should include the following language if they have an advance transition process for current members:\]](#) Work with your doctor (or other prescriber) and ask us to make an exception to cover the drug.
  - You can ask for an exception before next year, and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement).
  - To learn what you must do to ask for an exception, refer to **Chapter 9** of your *Member Handbook* or call Member Services at the numbers at the bottom of the page.
  - If you need help asking for an exception, contact Member Services [\[insert if applicable: or your care coordinator\]](#). Refer to **Chapters 2 and 3** of your *Member Handbook* to learn more about how to contact your care coordinator.
- [\[Plans should include the following language if all current members will not be transitioned in advance for the following year:\]](#) Ask us to cover a temporary supply of the drug.
  - In some situations, we cover a **temporary** supply of the drug during the first [\[must be at least 90\]](#) days of the calendar year.
  - This temporary supply is for up to [\[insert supply limit \(must be the number of days in plan's one-month supply\)\]](#) days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
  - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

different drug our plan covers or ask us to make an exception for you and cover your current drug.

*[Plans may include additional information about processes for transitioning current enrollees to formulary drugs when your formulary changes relative to the previous plan year.]*

*[Include language to explain whether current formulary exceptions will still be covered next year or a new one needs to be submitted.]*

**Changes to prescription drug costs** *[option for plans with two drug payment stages]*

*[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), should include the following information in the ANOC.]*

*[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]*

There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

| Stage 1<br>Initial Coverage Stage                                                                                                                                                                        | Stage 2<br>Catastrophic Coverage Stage                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay.<br><br>You begin this stage when you fill your first prescription of the year. | During this stage, the plan pays all of the costs of your drugs through December 31, 2024.<br><br>You begin this stage after you pay a certain amount of out-of-pocket costs. |

The Initial Coverage Stage ends when your total out-of-pocket costs for prescription drugs reaches *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you will pay for prescription drugs.

**E3. Stage 1: “Initial Coverage Stage”**

During the Initial Coverage Stage, our plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*[Insert if applicable: We moved some of the drugs on our Drug List to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our Drug List.]*

The following table shows your costs for drugs in each of our *[insert number of tiers]* drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

*[Plans must list all drug tiers in the following table.]*

|                                                                                                                                                                                                                           | 2023 (this year)                                                                                                                                           | 2024 (next year)                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |

The Initial Coverage Stage ends when your total out-of-pocket costs reach *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]*. At that point the Catastrophic Coverage Stage begins. The plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information how much you pay for prescription drugs.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

E4. Stage 2: “Catastrophic Coverage Stage”

When you reach the out-of-pocket limit *[insert as applicable: \$<initial coverage limit> or \$<TrOOP amount>]* for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year.

- *[Plans that do not reduce the copays for [insert name of the Medicaid program]-covered drugs in the catastrophic coverage stage should insert the following language: To locate more information about your prescriptions that Medicare and [insert name of the Medicaid program] cover, refer to the List of Covered Drugs, [insert reference, as applicable].]*

Changes to prescription drug costs *[option for plans with a single payment stage]*

*[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following information.]*

*[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]*

*[Insert if applicable: We moved some of the drugs on the Drug List to a lower or higher drug tier. [Insert if applicable: If your drugs move from tier to tier, this could affect your copay.] To find out if your drugs are in a different tier, look them up in the Drug List.]*

The following table shows your costs for drugs in each of our *[insert number of tiers]* drug tiers.

*[Plans must list all drug tiers in the following table.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



|                                                                                                                                                                                                                           | 2023 (this year)                                                                                                                                           | 2024 (next year)                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |
| <b>Drugs in Tier &lt;Tier number&gt;</b><br><br><i>([Insert short description of tier (e.g., generic drugs)])</i><br><br>Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | <i>[Insert 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> | <i>[Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is \$&lt;XX&gt; per prescription.]</i> |

**F. Administrative changes**

*[Insert this section if applicable. Plans with administrative changes that impact members (e.g., change in contract or PBP number) may insert this section, include an introductory sentence that explains the general nature of administrative changes, and describe the specific changes in the table below. Plans that choose to omit this section should renumber the remaining sections as needed.]*

|                                                                                   | 2023 (this year)                                | 2024 (next year)                                |
|-----------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <i>[Insert a description of the administrative process/item that is changing]</i> | <i>[Insert 2023 administrative description]</i> | <i>[Insert 2024 administrative description]</i> |



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                   | 2023 (this year)                                | 2024 (next year)                                |
|-----------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <i>[Insert a description of the administrative process/item that is changing]</i> | <i>[Insert 2023 administrative description]</i> | <i>[Insert 2024 administrative description]</i> |

## G. Choosing a plan

### G1. Staying in our plan

We hope to keep you as a plan member. You do not have to do anything to stay in our plan. If you do **not** change to another Medicare plan or change to Original Medicare, you automatically stay enrolled as a member of our plan for 2024.

### G2. Changing plans

*[Plans should add any additional Medicaid information as directed by the state.]* Most people with Medicare can end their membership during certain times of the year. Because you have *[Insert name of Medicaid program]*, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You moved out of our service area,
- Your eligibility for *[Insert name of Medicaid Program]* or Extra Help changed, **or**



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

### Your Medicare services

You have three options for getting your Medicare services. By choosing one of these options, you automatically end your membership in our plan. [\[Insert additional option to change to another integrated program as directed by the state.\]](#)

|                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1. You can change to:</b><br><br><b>Another Medicare health plan</b> <a href="#">[Insert additional instructions regarding Medicaid as directed by the state.]</a> | <b>Here is what to do:</b><br><br>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.<br><br>For PACE inquiries, call 1-855-921-PACE (7223).<br><br>If you need help or more information: <ul style="list-style-type: none"><li>• Call the <a href="#">[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</a> For more information or to find a local <a href="#">[insert name of SHIP office]</a> office in your area, please visit <a href="#">[insert website address]</a>.</li></ul><br><b>OR</b><br><br>Enroll in a new Medicare plan.<br><br>You will automatically be disenrolled from our plan when your new plan's coverage begins.<br><br><a href="#">[Insert impact on Medicaid enrollment as directed by the state.]</a> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>2. You can change to:</b></p> <p><b>Original Medicare with a separate Medicare prescription drug plan</b></p> <p><i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i> For more information or to find a local <i>[insert name of office]</i> office in your area, please visit <i>[insert website address]</i>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare prescription drug plan.</p> <p>You will automatically be disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>3. You can change to:</b></p> <p><b>Original Medicare without a separate Medicare prescription drug plan</b></p> <p><i>[Insert additional instructions regarding Medicaid as directed by the state.]</i></p> <p><b>NOTE:</b> If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join.</p> <p>You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i></p> | <p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call <i>[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]</i></li></ul> <p>You will automatically be disenrolled from our plan when your Original Medicare coverage begins.</p> <p><i>[Insert impact on Medicaid enrollment as directed by the state.]</i></p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Your *[insert name of state Medicaid program]* services**

For questions about how to get your *[insert name of Medicaid program]* services after you leave our plan, contact *[insert name of program, phone number, days and hours of operation, and TTY number and website if applicable]*. Ask how joining another plan or returning to Original Medicare affects how you get your *[insert name of Medicaid program]* coverage.

**H. Getting help**

**H1. Our plan**

We're here to help if you have any questions. Call Member Services at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

**Read your *Member Handbook***



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits *[insert if applicable: and costs]* for 2024. It explains your rights and the rules to follow to get services and prescription drugs we cover.

*[If the ANOC is sent or provided separately from the Member Handbook, include the following: The Member Handbook for 2024 will be available by October 15.] [Insert if applicable: You can also review the <attached or enclosed or separately mailed> Member Handbook to find out if other benefit [insert if applicable: or cost] changes affect you.]* An up-to-date copy of the *Member Handbook* is available on our website at *<web address>*. You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2024.

#### Our website

You can visit our website at *<web address>*. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our Drug List (*List of Covered Drugs*).

### H2. *[Insert name of the State Health Insurance Assistance Program (SHIP)]*

You can also call the State Health Insurance Assistance Program (SHIP). In *[Insert name of state]* the SHIP is called the *[Insert name of program]*. *[Insert name of program staff]* can help you understand your plan choices and answer questions about switching plans. *[Insert name of program]* HICAP is not connected with us or with any insurance company or health plan. *[Insert name of program]* has trained counselors *[insert in every county or locations]* and services are free. *[Insert name of program]* phone number is *[TTY phone number is optional.]* For more information or to find a local *[Insert name of program]* office in your area, please visit *[insert website address]*.

**Commented [MJJ3]:** Is the intent to have a Staff Member's Name?

**Commented [MJJ4]:** Please clarify: What is HICAP and is it different from SHIP?

### H3. *[Insert State-specific name for ombudsman program]*

*[Insert this section if there is an ombudsman program in the state. Include a description of what the program can do, whether the services are free, and phone number. Please refer to an example of language below.]*

*[Optional language example: The Ombudsman Program can help you if you have a problem with our plan. The ombudsman's services are free and available in all languages. The Ombudsman Program:*

- Works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do.*
- Makes sure you have information related to your rights and protections and how you can get your concerns resolved.*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Is not connected with us or with any insurance company or health plan. The phone number for the Ombudsman Program is [insert phone number].*

#### **H4. Medicare**

To get information directly from Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

##### **Medicare's Website**

You can visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to [www.medicare.gov](http://www.medicare.gov) and click on "Find plans.")

##### **Medicare & You 2024**

You can read the *Medicare & You 2024* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf](http://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf)) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

*[Insert any additional sections as required by the state, such as the QIO or additional resources that might be available.]*

#### **H5. *[Insert state-specific name of Medicaid program.]***

*[Insert a description of the state Medicaid program's role and how to receive assistance from the state.]*

#### **H6. *[Insert additional resources if applicable]***

*[If applicable, insert a new section for each additional resource, including contact information and a description of their role.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## <Plan name> **Member Handbook**

- ❖ *[Plans may add a front cover to the Member Handbook that contains information such as the plan name, Member Handbook title, and contact information for Member Services. Plans may add a logo and/or photographs to the front cover as long as these elements do not make it difficult for members to read other information on the cover. If plans add a front cover, it must contain the Material ID.]*
- ❖ *[Plans must use the state-specific name for Medicaid in references to "Medicaid" in any plan-customized language throughout the Member Handbook.]*
- ❖ *[Plans may modify the language in the Member Handbook, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]*
- ❖ *[Throughout the document plans should update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medicaid plans, etc.)]*
- ❖ *[Where the Member Handbook uses "medical care," "medical services," or "health care services" to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]*
- ❖ *[Plans may change references to terms such as "member," "customer," "beneficiary," "member services," "health risk assessment," "care coordinator," "primary care provider," "prior authorization (PA)," "nursing facility", and "urgently needed care", etc. as instructed by the state or based on plan preference and update them consistently throughout the Member Handbook.]*
- ❖ *[Where the model material instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]*
- ❖ *[Throughout the Member Handbook, in addition to following all Medicare and Medicaid requirements in regulation and the Medicare Communications and Marketing Guidelines, plans must follow additional applicable style rules of the state, if any.]*
- ❖ *[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number as appropriate. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*
- ❖ *[Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:]*

**Commented [OME1]:** Global Comment for proposed integrated ANOC and EOC models: The content layout does not align with the current D-SNP model. UnitedHealthcare (UHC) recommends remaining consistent with the current models as creating a whole new format and content creates risk in developing the documents and increases time required to manage additional templates.

**Commented [OME2]:** Consistent with UHC's global comment above, this is an example of an inconsistency between the proposed integrated model vs. the DSNP model. In the DSNP model, plans are instructed to include "(Medicaid)" when it is not part of the Medicaid agency name. Would plans be required to do the same for Integrated plans?

**Commented [OME3]:** Would there be an approval process for state changes to the integrated plan materials?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



- *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).*
- *Ensure plan-customized text is in plain language and complies with reading level requirements established in by the state.*
- *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
- *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.*
- *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
- *Avoid separating a heading or subheading from the text that follows when paginating the model.*
- *Use universal symbols or commonly understood pictorials.*
- *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
- *Consider using regionally appropriate terms or common dialects in translated models.*
- *Include instructions and navigational aids in translated models in the translated language rather than in English.*
- *Consider producing translated models in large print.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

<start date> – <end date>

## Your Health and Drug Coverage under <plan name>

[Plans: Revise this language to reflect that the organization is providing both Medicaid and Medicare covered benefits, when applicable.]

[Optional: Insert member name.]

[Optional: Insert member address.]

**Commented [OME4]:** Please clarify: When would integrated plans not provide both sets of benefits?

### Member Handbook Introduction

This *Member Handbook*, otherwise known as the *Evidence of Coverage*, tells you about your coverage under our plan through <end date>. It explains health care services [plans may add references to other behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports, as needed]. Key terms and their definitions appear in alphabetical order in Chapter 12 of your *Member Handbook*.

**This is an important legal document. Keep it in a safe place.**

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means [insert plan name].

ATTENTION: If you speak [insert language of the disclaimer], free language assistance services are available to you. Call <plan name> Member Services at the number at the bottom of this page. The call is free. [This disclaimer must be included in all non-English languages that meet the Medicare or state thresholds for translation.]

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

[Plans also simply describe:

- how they request a member's preferred language other than English and/or alternate format,
- how they keep the member's information as a standing request for future mailings and communications so the member does not need to make a separate request each time, **and**
- how a member can change a standing request for preferred language and/or format.]

[Plans must include an overall Table of Contents for the Member Handbook after the Member Handbook Introduction and before the Member Handbook Disclaimers.]

**Commented [OME5]:** UHC recommends aligning with the DSNP model which eliminated the need to include a table of contents (TOC) before every chapter.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## Disclaimers

- ❖ *[Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidelines, and included in any state-specific guidance.]*
- ❖ *[Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, here.]*
- ❖ Coverage under *[insert plan name]* is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.

**Commented [OME6]:** Are these disclaimers different than the disclaimers included in the DSNP EOC model instructions?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

# Chapter 1: Getting started as a member

## Introduction

This chapter includes information about *[insert plan name]*, a health plan that *[insert description of the relationship such as covers or coordinates]* all of your Medicare and *[insert name of Medicaid program]* services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

*[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]*

Commented [OME7]: Can this be a single statement like "covers your Medicare and Medicaid services"?

## Table of Contents

A. Welcome to our plan ..... 7

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    B2. *[Insert name of Medicaid Program]* ..... 7

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**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## A. Welcome to our plan

*[Insert language to describe the relationship between the Medicare and Medicaid services. For example: Our plan provides Medicare and [insert name of Medicaid program] services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.]*

*[Plan can include language about itself.]*

**Commented [OME8]:** Please consider combining the intro paragraph that is included before the TOC with Section A. The content for the intro paragraph and section A is similar and placing a short paragraph before the TOC could be missed by members.

**Commented [OME9]:** Please advise what information should go here?

## B. Information about Medicare and *[Insert name of Medicaid Program]*

### B1. Medicare

Medicare is the federal health insurance program for:

- People 65 years of age or older,
- Some people under age 65 with certain disabilities, **and**
- People with end-stage renal disease (kidney failure).

### B2. *[Insert name of Medicaid Program]*

*[Insert name of the Medicaid program]* is the name of *[insert name of state]* Medicaid program. *[Insert name of Medicaid program]* is run by the state and is paid for by the state and the federal government. *[Insert name of Medicaid program]* helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- What counts as income and resources,
- Who is eligible,
- What services are covered, **and**
- The cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

*[Plans should revise this section to best reflect the coverage of the plan.]* Medicare and the state of *[insert name of state]* approved our plan. You can get Medicare and *[insert name of state Medicaid program]* services through our plan as long as:

**Commented [OME10]:** UHC recommends including standardized content/language rather than allowing input at a plan level.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We choose to offer the plan, **and**
- Medicare and the State of *[insert name of state]* allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and *[insert name of state program]* services is not affected.

---

## C. Advantages of our plan

*[Plans should revise this section to best reflect the coverage of the plan.]* You will now get all your covered Medicare and *[Insert name of Medicaid program]* services from our plan, including prescription drugs. **You do not pay extra to join this health plan.**

**Commented [OME11]:** UHC recommends including standardized content/language rather than allowing input at a plan level.

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **all** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

---

## D. Our plan's service area

*[Insert plan service area here or within an appendix. Include a map if one is available.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

*Use county name only if approved for entire county, for example: Our service area includes these counties in <State>: <counties>.*

*For an approved partial county, use county name plus approved ZIP code(s) that are excluded, for example: Our service area includes all parts of <county> with the exception of the following ZIP code(s): <ZIP code(s)>.*

*If needed, plans may insert a table with more than one row or a short, bulleted list to describe and illustrate their service area in a way that is easy to understand.]*

Only people who live in our service area can join our plan.

**You cannot stay in our plan if you move outside of our service area.** Refer to **Chapter 8** of your *Member Handbook* for more information about the effects of moving out of our service area.

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## E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- Live in our service area, **and**
- Have both Medicare Part A and Medicare Part B, **and**
- *Are currently eligible for [insert name of state Medicaid program], and*
- *[Insert any Medicaid requirements], and*
- Are a United States citizen or are lawfully present in the United States.

**Commented [OME12]:** UHC recommends deleting this bullet as it seems repetitive to the 3<sup>rd</sup> bullet which references eligibility under the state Medicaid program.

If you lose eligibility but can be expected to regain it within *[Insert number 1-6. Plans may choose any length of time from one to six months for deeming continued eligibility, as long as they apply the criteria consistently across all members and fully inform members of the policy.]* month(s), then you are still eligible for our plan.

Call Member Services for more information.

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## F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date *[Plans adjust this language if the state requirement is more stringent]*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.



We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs [\[add additional areas covered by HRA\]](#).

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

*[Plans may add additional language regarding information about joining the plans as directed by the state such as information about a continuity of care period or using doctors for a transition period.]*

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## G. Your care team and care plan

### G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, or other health person that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

### G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and [\[Insert as applicable: LTSS or other services\]](#).

Your care plan includes: [\[Update the description of the care plan and the process as outlined in your model of care \(MOC\)\]](#).

- Your health care goals.
- A timeline for getting the services you need.

Your care team meets with you after your health risk assessment. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

**Commented [OME13]:** Please clarify what constitutes "other services".



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H. Your monthly costs for *[insert plan name]*

*[Plans should revise this section to only include premium types that apply or delete if plan has no monthly premium and revise with “Our plan has no premium.”]*

Your costs may include the following:

- Plan premium (Section H.1)
- Monthly Medicare Part B Premium (Section H.2)
- Optional Supplemental Benefit Premium (Section H.3)

**In some situations, your plan premium could be less.**

*[Insert as appropriate, depending on whether SPAPs are discussed in Chapter 2: There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. OR The “Extra Help” program helps people with limited resources pay for their drugs.]* Chapter 2, Section H2 tells more about *[insert as applicable: these programs OR this program.]* If you qualify, enrolling in the program might lower your monthly plan premium.

If you *already enrolled* and are getting help from one of these programs, **the information about premiums in this *Member Handbook* *[insert as applicable: may OR does]* not apply to you.** *[If not applicable, omit information about the LIS Rider.]* We *[insert as appropriate: have included OR sent you]* a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

### H1. Plan premium

*[If applicable, plans should revise this section to indicate that the plan premium is paid on behalf of members (e.g. by “Extra Help”, Medicaid).]*

As a member of your plan, you pay a monthly plan premium. *[Select one of the following: For 2024, the monthly premium for *[insert 2024 plan name]* is *[insert monthly premium amount]*. OR The monthly premium amount for *[insert 2024 plan name]* is listed in *[describe attachment.]* *[Plans may insert a list or table with the state/region and monthly plan premium amount for each area included within the EOC. Plans may also include premium(s) in an attachment to the EOC.]**

*[Plans with no premium should delete this section.]*

**Commented [OME14]:** Please clarify the instruction here. If plan has no monthly premium, would plans delete the first bullet and all of the content under section H1. Plan Premium? Also, if plans delete, can plans renumber the sections?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

## H2. Monthly Medicare Part B Premium

### Many members are required to pay other Medicare premiums

*[Plans that include a Medicare Part B premium reduction benefit may describe the benefit within this section.]*

*[Plans that do not have any members paying Medicare premiums or plans whose members must pay the full Medicare Part B premium should modify this section.]*

*[Plans with no monthly premium, omit: In addition to paying the monthly plan premium,]* some members are required to pay other Medicare premiums. As explained in Section H2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most *[insert 2024 plan name]* members, Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and for your Medicare Part B premium.

**If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.** This includes your premium for Medicare Part B. It may also include a premium for Medicare Part A which affects members who aren't eligible for premium free Medicare Part A. **In addition, please contact Member Services or your care coordinator and inform them of this change.**

### H3. Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called "optional supplemental benefits," then you pay additional premium each month for these extra benefits. Refer to Chapter 4, Section E for details. *[If the plan describes optional supplemental benefits within Chapter 4, then the plan must include the premium amounts for those benefits in this section.]*

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## I. Your Member Handbook

Your *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* found on our website *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

The contract is in effect for the months you are enrolled in our plan between *[insert start date]* and *[insert end date]*.

**Commented [OME15]:** Please clarify: Plans are usually effective from January 1 – December 31. Would there ever be a situation where plans would need to create non-calendar year materials?



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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## J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, *[insert if applicable: information about how to access]* a *Provider and Pharmacy Directory*, *[plans that limit DME brands and manufacturers insert: a List of Durable Medical Equipment,]* and *[insert if applicable: information about how to access]* a *List of Covered Drugs*, also known as a *Formulary*.

### J1. Your Member ID Card

Under our plan, you have one card for your Medicare and *[insert name of Medicaid program]* services, including long-term services and supports, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:

*[Insert picture of front and back of plan ID card. Mark it as a sample card (for example, by superimposing the word “sample” on the image of the card).]*

If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your *[insert name of Medicaid program]* card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Member Handbook* to find out what to do if you get a bill from a provider.

*[If members must use a different card for any Medicaid services, include a description here.]*

### J2. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Provider and Pharmacy Directory* at *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

*[Plans must add information describing the information available in the directory.]*

*[Plans may add information describing the use of providers during a transition period as directed by the state.]*



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

**Definition of network providers**

- Our network providers include:
  - Doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - LTSS, behavioral health services, home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

**Definition of network pharmacies**

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to [\[insert if applicable: help you\]](#) pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

[\[Plans that limit DME brands and manufacturers insert the following section \(for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual:](#)

**List of Durable Medical Equipment (DME)**

We sent you our List of Durable Medical Equipment (DME) with this *Member Handbook*. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at the address at the bottom of the page. Refer to **Chapters 3 and 4** of your *Member Handbook* to learn more about DME equipment.]

**J3. List of Covered Drugs**

The plan has a *List of Covered Drugs*. We call it the “Drug List” for short. It tells you which prescription drugs our plan covers.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Member Handbook* for more information.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Each year, we send you [\[insert if applicable: information about how to access\]](#) the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website [at the address at the bottom of the page](#). [\[Plans may insert information about Medicaid covered drugs.\]](#)

#### J4. The Explanation of Benefits

When you use your Medicare Part D prescription drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D prescription drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take [\[insert, as applicable: such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options\]](#).

**Chapter 6** of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

[\[Plans may insert other methods for members to get their EOB.\]](#)

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## K. Keeping your membership record up to date

[\[In the Table of Contents, section heading, and text, plans substitute the name for this file if it differs from "membership record."\]](#)

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you.**

Tell us right away about the following:

- Changes to your name, your address, or your phone number.
- Changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation.
- Any liability claims, such as claims from an automobile accident.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Admission to a nursing facility or hospital.
- Care from a hospital or emergency room.
- Changes in your caregiver (or anyone responsible for you.)
- You take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

*[Plans that allow members to update this information online may describe that option here.]*

*[Plans may add information regarding keeping their Medicaid information updated as directed by the state.]*

### **K1. Privacy of personal health information (PHI)**

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Member Handbook*.



**If you have questions**, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.