2009 Standardized Combined ANOC/EOC

Instructions to Plans

The 2009 Standardized Combined ANOC/EOC must be used by all Medicare Advantage Plans (MAs), Medicare Advantage Prescription Drug Plans (MA-PDs), Medicare Prescription Drug Plans (PDPs), and Medicare Cost plans. All sections of the standardized ANOC/EOC must be sent together in the same envelope, along with the plan formulary, for arrival no later than October 31.

Text in this document is standardized and must be used exactly as provided, unless indicated otherwise. All instructions to plans should be deleted from the member document. General guidelines are listed below:

Information that needs to be inserted or chosen by plans: [in brackets]
Instructions to Plans: [***Note:*** xxx]
Instructions to specific plan types: [***Note to PFFS plans:*** xxx]
Instructions including specific text to be added: [***Note:*** insert "xxx"]
Add if applicable information: [***Add if applicable****:* xxx]
Optional information: [***Optional:*** xxx]

The information in the ANOC/EOC is color-coded to help identify information by plan type. (See chart below.) When developing the ANOC/EOC, plan staff need to identify all of the categories their plan can be classified under and use the language in those sections, deleting language not applicable to the plan type described in that EOC. The color-coding is for plan use only, and should be changed in member document.

Unless otherwise noted, Cost plans should include all sections addressed to MA plans. (Cost plans that do not offer Part D should include sections addressed to MA-only plans, and Cost plans that offer Part D as Cost-PD plans should include sections addressed to MA-PD plans.) When necessary, Cost plans may edit incongruous references to "Part C" throughout the document.

The color-coded list is below.

All Plan Types	**Black**
All plan types except PDP	**Indigo Blue**
MA-PD and PDP Plans	**Red**
MA-only plans	**Brown**

PRA Disclosure Statement

HMO Plans	**Green**
PPO Plans	**Sky Blue**
PFFS Plans	**Violet**
Cost Plans	**Orange**
SNP Plans	**Bright Blue**
MSA Plans	**Dark Pink**
Regional PPOs (RPPOs)	**Dark Yellow**
Point of Service Plans	**Bright Green**

Special instructions:

1) The ANOC/EOC must be submitted through File & Use Certification. Plans must submit an attestation checklist with the document to confirm no standardized language has been altered.
    a. CMS will release the checklists through HPMS prior to September 1, 2008.
    b. CMS will conduct retrospective reviews to ensure clarity and accuracy of the materials.

2) Fully integrated Medicare/Medicaid SNPs are not required to use the standardized combined ANOC/EOC document. Fully-integrated SNPs should send an ANOC with an SB for receipt by Oct 31 and the state-integrated EOC for receipt by Dec 31. These integrated ANOC & EOC documents will need to be submitted for 45-day review.

3) Plans can modify or delete standardized language in the situations described below.
    a. Plans should modify or delete, as necessary for your plan, all references under "all Plan Types" not relevant to your plan.
    b. Plans using an open access model: modify or delete, as necessary for your plan, all references to PCP, referrals, etc.
    c. Plans not offering a Part D benefit package: modify or delete, as necessary for your plan, all references to Part D benefits.
    d. HMO-POS plans can modify language related to network providers when necessary to clarify when a POS benefit may furnish coverage.
    e. All references to Member Services, Pharmacy Directory, and Provider Directory can be changed to the appropriate name your plan uses.
    f. Throughout the document, plans may replace references to broad organization names (SHIPs, QIOs, SPAPs, etc) with the state-specific name in the areas where the product is being

offered. Plans may choose to use the broad organization name throughout the document, but if doing so must refer the beneficiary to Section 8 for information on their state program.

g. Plans may include multiple benefit packages within one ANOC/EOC, however if doing so the plans must be clearly differentiated. The EOC can be edited to ensure that members easily understand exactly which plan they are enrolled in.

4) Plans will not be permitted a global or ad-hoc process for customizing standard language. Plans must use standard language as given in the document.
   a. Plans may make minor grammatical or punctuation changes as necessary and submit as standardized.
   b. Standardized text must be used and must remain in the exact order given in the standardized document. The document can be formatted as desired (i.e. font style, margins), so long as all changes meet CMS Marketing Guidelines and other CMS guidance.

5) All sections of the standardized ANOC/EOC must be sent together in the same envelope, along with the plan formulary, for arrival no later than October 31.
   a. Plans may reproduce sections of the ANOC/EOC separately; however, the number of sections should be as limited as possible. Based on industry feedback, the model document has been reordered to facilitate this request. If printed separately, the documents should still be packaged in the order this model provides – Cover Letter, ANOC benefits chart, ANOC text, EOC (the sections of the EOC must stay in the same order as the standardized model 1 – 10), Index.
      i. The text section of the ANOC (begins with the heading "This is Your Annual Notice of Change") and EOC Sections 1 – 6 use standardized language across multiple plans in an MAO. The benefits chart section of the ANOC and EOC Sections 7-10 are all the sections that may include pieces that could need to be populated with PBP/plan-specific information.
   b. The LIS Rider may be mailed in a separate envelope from the ANOC/EOC, but also must be received by members by October 31.
   c. The SB does not need to be sent with the combined ANOC/EOC, but must be available upon request for all members.

6) The 2009 combined ANOC/EOC notice must be sent to all new members who enroll in a plan between October 31 and November 30, 2008. Plans sending stand-alone EOC to new enrollees with effective dates of 1/1/09 and later may edit document to remove all references to ANOC (even if not bracketed) and send EOC portion only. Plans doing so do not need to resubmit the stand-alone EOC under a new code for CMS approval.

PRA Disclosure Statement

7) Please note that entities offering employer sponsored group plans (these include employer/union-only group waiver plans (EGWPs) or individual plans sponsored by employer/union groups) are subject to all applicable Medicare dissemination and disclosure requirements (including any requirements related to the timing of these materials) unless specifically waived or modified. Please note the following important employer group waivers/modifications as they relate to the requirements in these combined ANOC/EOC instructions:
    a. Current CMS guidance does not require entities to submit employer group plan dissemination materials for prior review and approval;
    b. CMS has waived any requirements that would otherwise prohibit entities offering employer group plans from modifying required standardized model combined ANOC/EOC language to allow these entities to customize these materials to the extent those customized materials will more clearly and accurately describe the benefits available to employer/union group plan members;
    c. With regard to premium amounts that are required to be accurately reflected on these standardized model materials, entities should ensure these materials accurately reflect the actual premium amount the beneficiary pays when the supplemental coverage, if any, and any corresponding employer/union premium subsidization is taken into account. If accurate premium information concerning the amount the beneficiary actually pays is not available, the entity may use the standardized model language in lieu of providing actual premium amounts (e.g., contact your employer group plan benefit administrator); and
    d. CMS has waived/modified applicable timing requirements in certain circumstances such as where a particular employer/union group plan sponsor has an open enrollment period that differs from Medicare's open enrollment period. In these situations, the combined ANOC/EOC must be received no later than 15 days before the particular employer/union sponsor's open enrollment period begins.

    See Medicare Managed Care Manual (Chapter 9) and Prescription Drug Manual (Chapter 12) for more detailed information concerning employer group plans and applicable CMS waivers/modifications.

8) CMS will release standardized documents broken down by plan type prior to June 1.

[Cover]

Your Medicare [Health Benefits and Services/Prescription Drug Coverage] as a Member of [Plan Name]

[Beneficiary name]
[Beneficiary address]

This mailing gives you the details about your Medicare [health and/or prescription drug] coverage from January 1 – December 31, 2009, and explains how to get the [health care and/or prescription drugs] you need. This is an important legal document. Please keep it in a safe place.

[Name of organization] Member Services:
For help or information, please call Member Services or go to our Plan website at [insert URL].

[Plan may add local phone number if desired]
[1-XXX-XXX-XXXX] (Calls to these numbers are free)
[TTY; TDD] users call: [1-XXX-XXX-XXXX]

Hours of Operation:
[Insert hours of operation, including information on use of alternative technologies]

This Plan is offered by [MAO], referred throughout the EOC as "we", "us" or "our." [Plan name] is referred to as "Plan" or "our Plan." Our organization contracts with the Federal government.

This information [may be/is] available in a different format, including [list all available formats, including languages, large print, and audio tapes]. Please call Member Services at the number listed above if you need plan information in another format or language.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

[Plans offering the ANOC/EOC in Spanish (or other languages) should include the above paragraph in the English document in Spanish (or other languages as applicable).]

[Material ID number]
[mm/yyyy]

All plan types

[***Note:*** Plans that wish to edit table below with LIS-specific information may do so.]

Important Information

[***Note to Plans with no plan, premium, benefit, or cost-sharing changes for 2009:*** you may delete the text and chart that follows the heading "How Your Plan Will Change For 2009" and move the introductory paragraph to immediately below "This is Your Annual Notice of Change." Edit the paragraph to reflect there are no plan changes and insert: "Our plan premium, benefits, [formulary] and cost-sharing will be exactly the same in 2009 as they are in 2008. Medicare has reviewed and approved the [benefits described and/or covered drugs listed in the formulary] for our Plan in 2009. Please see Section 10 for more information about what you pay for coverage through our Plan."]

How Your Plan Will Change For 2009

[***Note***: The organization may modify this introductory paragraph to tailor to its needs, as long as the paragraph is kept brief.] This is the time of year when we like to thank you for your membership and let you know of new plan changes for the upcoming year. Beginning January 1, 2009, there will be some changes to our Plan. [***Note to PDPs rolling members into new plan or consolidating or to any plan changing the plan product name in 2009*** insert "We also want to take this opportunity to let you know of our new plan name for the upcoming year."]

You are enrolled in [Plan Name] in 2008 and your plan coverage and costs are changing. All changes will be effective January 1, 2009. [***Note to existing PDPs that will lose certain LIS beneficiaries to re-assignment to a plan within the same PDP sponsoring organization:*** delete the previous sentence and insert the following: "Because the premium for the plan you had in 2008 is increasing in 2009, you will be moved to [insert 2009 plan name], where you won't have to pay any monthly premium in 2009, unless you tell us you wish to stay with [insert 2008 plan name], the plan you have in 2008. Please call Member Services if you choose to stay with [insert 2008 plan name]. Note that if you do stay with [insert 2008 plan name], you will be responsible for paying a premium.]

This is just a brief summary of the changes in your plan for 2009. **Make sure to read the next few pages for answers to important questions you may be asking.** If you have any questions,

call Member Services. Note: If you are receiving help from your state Medicaid agency or State Pharmaceutical Assistance Program (SPAP), such as a reduced co-payment, these reductions are not reflected in this packet. Please call your state or SPAP at the number listed in Section 8 if you have questions.

	2008 [***Optional:*** [Plan name]]	**2009** [***Optional:*** [Plan name]]
Monthly Premium [***Note to MA-PD and PDPs, include if applicable:*** "This monthly premium amount does not include any late enrollment penalty you may be responsible for paying (see Section 2 in the EOC for more information)."]	$[current premium]	$[new premium] [***Insert if applicable:*** You are receiving a subsidy from your current or former employer or union to pay for some or all of your Plan premium. Please contact your employer or union's group benefit plan administrator for information about your Plan premium.]
Benefit changes	[***Note to MA and MA-PD Plans:*** list below all benefit changes as applicable to the plan, including changes in cost-sharing, current benefits that will no longer be offered, and new benefits, including any new optional supplemental benefits and the premiums for those benefits. For consistency, list changes in same order as EOC. See examples below.]	
[***Example:*** Visit to primary care physician]	[***Example:*** $10 co-payment]	[***Example:*** $15 co-payment]
[***Example:*** Annual physical]	[***Example:*** Not covered]	[***Example:*** Covered]
Changes to Part D prescription drug benefits	[***Note to PDP and MA-PD Plans:*** list below all benefit changes as applicable to the plan, including changes in cost-sharing, covered drugs, tier structure, types of drugs in each tier, or addition or removal of utilization	

	management tools. For consistency, list changes in same order as EOC. See examples below.]	
[***Example:*** Deductible]	[***Example:*** $0 deductible]	[***Example:*** $100 deductible]
[***Example:*** Tier 1 co-payments for generic drugs]	[***Example:*** $4 co-payment for one month (31-day) supply at retail pharmacy $10 co-payment for three-month (90-day) supply from mail-order pharmacy]	[***Example:*** $6 co-payment for one month (31-day) supply at retail pharmacy $12 co-payment for three-month (90-day) supply from mail-order pharmacy]

With this notice, you also received a 2009 Evidence of Coverage [and a new formulary] that will be effective January 1, 2009. Medicare has reviewed and approved the [benefits described and/or covered drugs listed in the formulary]. Please see Section 10 for more information about the [benefits and/or drug coverage] described in the table above.

[***Note to MA-PD and PDP organizations that offers multiple plans in the service area***: include "We also offer other plans in your area that may have different premiums, co-payments, or coinsurance amounts. To learn more about what other plans we have available in your area, call Member Services." Plans may choose to insert a list of other plans available here as well.]

This is Your Annual Notice of Change

Why am I receiving this information?

We are sending this Annual Notice of Change (ANOC) so you can review the 2009 coverage offered through this plan. [***Note to Cost Plans:*** insert "Since [plan] is a type of Medicare plan called a Medicare Cost Plan, you may leave this plan at anytime and return to the Original Medicare plan. However, while you may leave our Plan at any time, you are generally limited to certain times of the year when you may join other Medicare plans."] Each year from November 15 through December 31, you may make a change to your Medicare plan and Medicare prescription drug coverage, with your new plan beginning on January 1. **[Note to closed Cost Plans: Insert "Please keep in mind this plan is closed to enrollment. If you leave Our plan**

you will not be able to re-enroll in the future."] **If you want to stay in our Plan, you don't need to do anything. You will still be a member of our Plan for the coming year.**

[***Note to Cost Plans that offer Part D:*** include "As a member of our plan, you may choose the Medicare prescription drug coverage our Plan offers you or you may join any Medicare Prescription Drug Plan that is offered in your area.] [***Note to Cost Plans:*** include "Should you leave our plan and want to rejoin during the year, [insert "call Member Services" or "you may join during [insert open enrollment period]."]

Note: If you are a member of [***Part D Plans offered in a service area with an SPAP insert:*** "a State Pharmaceutical Assistance Program (SPAP) or"] an employer group, you may be required to belong to a specific plan in order to continue to get the additional benefits you may be receiving. Please check with your [SPAP or] employer before switching to another prescription drug program. [The phone number for your SPAP can be found in Section 8 of the Evidence of Coverage.]

MA-PDs and PDPs

What if my drugs are not on the formulary or are in a more expensive cost-sharing tier?

[We have changed our formulary.] [The new formulary may be different from the one you are using.] [We have added, removed, or placed more limitations on some of the drugs we cover.] Please review the formulary to see if we still cover the drugs that you currently take. [*If including a complete formulary, use the following language:* "The enclosed formulary can also be found on our website or you may call Member Services if you need any help locating a certain drug."] [*If including an abridged formulary, use the following language:* "To get a complete listing of all the drugs we cover, you may visit our website or call Member Services."]

[***Note:*** Insert the following language if you allow enrollees to request exceptions for the upcoming plan year before the upcoming plan year begins: "If a drug we currently cover for you is not on our new formulary, you will need to talk with your doctor about taking an alternative drug that is available on our new formulary. If you wish to continue coverage of your current drug, you or your doctor can request a formulary exception. [If a drug we currently cover for you is on our new formulary but has been moved

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

to a higher non-preferred cost-sharing tier, you can talk with your doctor about taking an alternative drug that is available in a lower cost-sharing tier. If you wish to pay the lower preferred cost-sharing amount for your current drug, you or your doctor can request a tiering exception.] If you or your doctor would like to request an exception, the request should be made by [insert date]. If a formulary exception request is approved, we will continue covering your current drug on January 1. [If a tiering exception request is approved, we will cover your current drug at the preferred cost-sharing amount on January 1.]"]

[***Note:*** Insert the following language if you do not allow enrollees to request exceptions for the upcoming plan year before the upcoming plan year begins "If a drug we currently cover for you is not on our new formulary, you will need to talk to your doctor about taking an alternative drug that is available on our new formulary. If you wish to continue coverage of your current drug, you or your doctor can request a formulary exception on or after January 1. Beginning January 1, you will get a temporary supply of the drug we currently cover for you that is not on our new formulary. You will need to talk to your doctor about switching to a covered drug, or request a formulary exception before your temporary supply runs out. [If a drug we currently cover for you is on our new formulary but has been moved to a higher non-preferred cost-sharing tier, you can talk with your doctor about taking an alternative drug that is available in a lower cost-sharing tier. If you wish to pay the lower preferred cost-sharing amount for your current drug, you or your doctor can request a tiering exception on or after January 1.]"] Please refer to Section 5 in the Evidence of Coverage for instructions on how to file an exception.

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

MA-PDs and PDPs

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

What do I need to know if I qualify for extra help (the low-income subsidy, or LIS) from Medicare to pay for my prescription drugs?

If you continue to qualify for the same amount of extra help next year, the table below tells you how your prescription costs will change. You will also receive an "**Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs"** before October 31, 2008, that has more specific information on your premiums and cost-sharing in 2009. Read this important information carefully. If you don't know what level of extra help you qualify for, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you pay this much this year (2008)	You will pay this much next year (2009)
$0 deductible	$0 deductible
$56 deductible	$[xx] deductible
$1.05 for generics and brands that are treated as generics $3.10 for brand name drugs	$[xx] for generics and brands that are treated as generics $[xx] for brand name drugs
$2.25 for generics and brands that are treated as generics $5.60 for brand name drugs	$[xx] for generics and brands that are treated as generics $[xx] for brand name drugs
15% coinsurance for all drugs	[xx]% coinsurance for all drugs

If you qualify for extra help, you pay $0 or a reduced monthly Part D premium. If you continue to qualify for the same amount of extra help in 2009, the table below tells how much you will pay for a monthly premium. (This doesn't include any Medicare Part B [***Add if applicable:*** Part C or supplemental Part D] premium you may have to pay.) If you don't know your level of extra help, call Member Services.

Your level of extra help	Monthly Premium for [Plan Name]
100%	$[xx.xx]
75%	$[xx.xx]
50%	$[xx.xx]

25%	$[xx.xx]

[***Note to existing PDPs that will lose certain LIS beneficiaries to re-assignment to a different PDP sponsoring organization:*** Sponsors must send either the *"Optional Notice for "Losing Plan" to LIS beneficiaries Re-Assigned to Different PDP Sponsor"* that is provided in the PDP Enrollment & Disenrollment Guidance OR the ANOC. If choosing to send the ANOC, include the following language: "If you qualify for extra help, you will get a blue letter from Medicare by early November. This letter explains that Medicare will enroll you in a new Medicare drug plan to lower your monthly premium cost in 2009 unless you tell us you want to stay with our Plan instead. Please call Member Services if you want to stay with our Plan. Staying in our Plan will cost you more in premiums than moving to the new plan."]

MA-only plans

What if I don't have drug coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage?

Our plan does not include Medicare prescription drug coverage. If you haven't had other prescription drug coverage that was creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage), you may have to pay a late enrollment penalty when you sign up for Medicare prescription drug coverage. You will pay the penalty if you go without creditable coverage for a continuous period of 63 days or more. The longer you wait to enroll in a Medicare drug plan, the higher the penalty may be. If you have had creditable prescription drug coverage, your employer/union will notify you each year if it continues to be creditable coverage. If you received a notice this year that you no longer have creditable coverage, consider joining a Medicare health plan that offers prescription drug coverage. [***Note to Cost plans and PFFS plans not offering prescription drug coverage****:* insert "If you are a member of this plan and want to get Medicare prescription drug coverage, you may join a Medicare Prescription Drug Plan."] [***Note to Cost plan organizations that offer other plans with Part D coverage:*** insert "If you are a member of this plan and want to get Medicare prescription drug coverage, you may join a plan with prescription drug coverage offered by our organization or buy a separate Medicare prescription drug plan.] [***Note to Medicare Advantage Plans that offer other plans with Medicare Prescription Drug coverage****:* insert "Our organization offers the following plans that include Medicare prescription drug coverage:" and list plans with Medicare Prescription Drug coverage available in the service area & Member Services contact]. To find other plans available in your area, visit www.medicare.gov and under

"Search Tools" select "Compare Medicare Prescription Drug Plans." Or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you join another Medicare Health Plan or a Medicare Prescription Drug Plan [***Note to Cost plans and PFFS plans not offering prescription drug coverage:*** do not include phrase "or a Medicare Prescription Drug Plan"] you will be disenrolled from our Plan when your enrollment in the new plan begins.

All Plan Types

Where can I get more information?

The Evidence of Coverage on the following pages has more information on our Plan's coverage, including information on how to make changes to your membership in Section 6.

Please call Member Services if you have any questions. You can also get information about the Medicare program and other Medicare plans available by visiting www.medicare.gov 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.

PRA Disclosure Statement

This is Your 2009 Evidence of Coverage (EOC)

Table of Contents

Other enclosures:
Formulary
[Plans may list other enclosed EOC-related documents as needed.]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

1. Introduction

All Plan Types

Thank you for being a member of our Plan!

This is your Evidence of Coverage, which explains how to get your Medicare [health care and/or drug coverage] through our Plan, a [insert plan type]; [***Note to all plan types except PDP:*** include "you are still covered by Medicare, but"] you are getting your [health care and/or Medicare prescription drug coverage] through our Plan. ***[SNPs with an arrangement with the State may revise this language to reflect, when applicable, that the organization is providing both Medicaid and Medicare covered benefits.]***

This Evidence of Coverage, together with your enrollment form, riders [including optional supplemental benefit brochures], [formulary,] and amendments that we send to you, is our contract with you. The Evidence of Coverage explains your rights, benefits, and responsibilities as a member of our Plan and is in effect from January 1, 2009 - December 31, 2009. [***Note to organizations that list more than one plan offering in Evidence of Coverage: insert*** "There is more than one plan described in this EOC. Please refer to the cover sheet you received with this information to identify which plan you are enrolled in."]

This Evidence of Coverage will explain to you:
[***Note to MA-only plans:*** Do not include references to prescriptions.]

- What is covered by our Plan and what isn't covered.
- How to get [the care you need or your prescriptions filled], including some rules you must follow.
- What you will have to pay for your [health care or prescriptions].
- What to do if you are unhappy about something related to getting your [covered services or prescriptions filled].
- How to leave our Plan, [and other Medicare options that are available, including your options for continuing Medicare prescription drug coverage].

This Section of the EOC has important information about:

- Eligibility requirements

- The geographic service area of our Plan
- Keeping your membership record up-to-date
- Materials that you will receive from our Plan
- Paying your plan premiums
- [***Note to MA-PDs and PDPs:*** include bullet] Late enrollment penalty
- [***Note to MA-PDs and PDPs:*** include bullet] Extra help available from Medicare to help pay your plan costs

All Plan Types except MSA

Eligibility Requirements

To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, and [***Note to PDP-only plans***: replace this "and" with "or"] enrolled in Medicare Part B [***Note to Cost plans:*** add "or enrolled in Medicare Part B only"] [Note to MA plans and Cost Plans: Insert "and not have End Stage Renal Disease (ESRD), with limited exceptions, such as if you are already a member of our plan."]. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

[***Note to Medicare Saving Account (MSA) Plans:*** insert following section]
You are not eligible for our plan if you:

- Have health coverage that would cover the Medicare MSA plan deductible, including benefits under an employer or union group health plan.
- Get benefits from the Department of Defense (TRICARE) or the Department of Veterans Affairs.
- Are a retired Federal government employee and part of the Federal Employees Health Benefits Program (FEHBP).
- Are eligible for Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources).
- Have end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).
- Are currently getting hospice care.
- Live outside the United States more than 183 days a year.

If after you enroll in our plan, you begin hospice care or you develop end-stage renal disease, you can remain a member of our plan. However, if you no longer meet the other eligibility conditions, we will have to end your membership, as described in Section 6.

[*Note to SNPs:* insert following paragraph if applicable to your plan type]

Special Eligibility Requirements for this Plan

Our Plan is designed to meet the needs of people who [insert type of SNP category, such as: "are eligible for both Medicare and Medicaid," "live in [type of institution]," "have [chronic or disabling condition."]]. If you no longer meet the special eligibility requirements of our plan, your membership in this plan will end after [insert applicable grace period]. You will receive a notice from us informing you of the end of your membership and your options. If you have any questions about your eligibility, please contact Member Services.

[***Chronic/disabling condition SNPs, insert*** "Below is a list of the chronic or disabling condition[s] that meet the eligibility requirements for our Plan:" and add list specifying the chronic or disabling condition(s) (including specific lab values, if applicable – e.g., Total Blood Cholesterol exceeding 240mg, without medication)]

All Plan Types

The geographic service area for our Plan.

The [state(s) and counties [and parts of counties] or Regions] in our service area are listed below.

[***Optional info:*** You may include a map of the area (in addition to listing the service area), and modify the prior sentence to refer readers to the map.]

[***Note:*** Insert plan service area listing. Use county name only if approved for entire county. For partially approved counties, use county name plus zip code, e.g., "county name, the following zip codes only: [xxxxx]"]

[***Optional info:*** multi-state plans may include the following: We offer coverage in [several/all] states [and territories]. However, there may be cost or other differences between the plans we offer in each state. If you move out of the state where you live into a state listed above that is still within our service area, you must call Member Services in order to update your information. If you move into a state not listed above, and outside of our service area, you cannot remain a

member of our plan. Please call Member Services to find out if we have a plan in your new state.]

All Plan Types

How do I keep my membership record up to date?

[Note: In the heading and in this paragraph, substitute the name you use for this file if different from "membership record."]

We have a membership record about you. Your membership record has information from your enrollment form, including your address and telephone number. [Note: Do not insert the following sentence if you are a PDP: "It shows your specific Plan coverage, including [Note: insert as appropriate] the [Primary CarePhysician/Medical Group/IPA] you chose when you enrolled] and other information."] [Doctors,] [hospitals,] [pharmacists,] [and other network providers] use your membership record to know what [services or] [drugs] are covered for you. Section 3 tells how we protect the privacy of your personal health information. Please help us keep your membership record up to date by telling Member Services if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Please help us keep your membership record up to date by telling Member Services if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

All Plan Types except PDPs and MSAs

[***Note to MA-PD plans that use separate membership cards for health and drug coverage:*** edit following paragraph to reflect use of multiple cards.]

Plan membership card

While you are a member of our Plan, you must use our membership card for [services covered by this plan [and/or] prescription drug coverage at network pharmacies]. While you are a member of our Plan you must not use your red, white, and blue Medicare card to get covered [services, items [and/or] drugs]. Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself. [***Note***: Medicare Cost plans should change the language in this section to indicate that members are free to use their Medicare card and receive services under the original Medicare program, and pay original Medicare cost-sharing.]

[***Note to SNPs***: Plans may revise this language to reflect, when applicable, that the members will use the plan card exclusively or the plan card and a Medicaid card.]

Please carry your membership card that we gave you at all times and remember to show your card when you get covered [services, items [and/or] drugs]. If your membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. [There is a sample card in Section 10 to show you what it looks like.]

PDP

Plan membership card

Now that you are a member of our Plan, you must use our membership card for prescription drug coverage at network pharmacies. You should continue to use your red, white, and blue Medicare card to get covered services and items under Original Medicare.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered prescription drugs. If your membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. There is a sample card in Section 10 to show you what it looks like.

MSA Plans

MSA Plan Membership Card

Now that you are a member of our Plan, you should use our membership card for services covered by this plan. If you receive services on your own and do not use our membership card,

you will have to later submit any claim to our Plan that you pay on your own. You will also get a [bank or debit] card to use to withdraw money from your MSA savings account. If either of these cards are damaged, lost, or stolen, you may call Member Services. Note that while you are a member of our Plan you must not use your red, white, and blue Medicare card to get covered services or items because Original Medicare will not pay for them. Keep your red, white, and blue Medicare card in a safe place in case you need it later.

There is a sample MSA plan membership card in Section 10 to show you what it looks like.

All plan types except PDP-only

The Provider Directory gives you a list of network providers

[Note: plans without a provider directory exclude following paragraph.]
Every year that you are a member of our Plan, we will send you either a Provider Directory or an update to your Provider Directory, which lists our network providers. If you don't have the Provider Directory, you can get a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. [Note: It is optional to add more detail to this paragraph that describes what information is available in your provider directory, on your website, or from Member Services such as, "Member Services can give you the most up-to-date information about changes in our network providers and about which ones are accepting new patients." You may also note that a complete list of network providers is available on your website.]

HMO Plans

You [may be required to use; must use] network providers for services to be covered by us at plan cost-sharing levels, except in emergencies, for urgently needed care when our network is not available, or for out of the area dialysis services. See the benefits chart in Section 10 for more specific out-of-network coverage information.

[***Note to Plans with Point –of-Service (POS) option***: briefly describe POS option here. The details of POS should be addressed in Section 2.]

PPO Plans

You may pay more for services if you do not use a network provider, except in emergencies, urgently needed care when our network is not available, and for out of area dialysis services.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

[***Note to regional PPOs:*** RPPOs that CMS has granted permission to use the exception in § 422.112(a) (1) (ii) to meet access requirements should insert: "Because our Plan is a Regional Preferred Provider Organization, if no contracted network provider is readily available you can access care at in-network cost-sharing from an out-of-network provider. Call Member Services to let us know you need to see an out-of-network provider, or to get help finding an out-of-network provider.]

Cost plans

You [may be required to use; must use] network providers for services to be covered by us at plan cost-sharing levels, except in emergencies or for urgently needed care. See the benefits chart in Section 10 for more specific out-of-network coverage information.

Network PFFS Plans

[***Note:*** This section doesn't apply to non-network PFFS plans.]
[***Note to PFFS plans:*** When this document uses the term "network PFFS plan," it is referring to a PFFS plan that has some or all categories of providers under direct contract in order to (1) meet Medicare access requirement under 42 CFR §422.114(a)(2)(ii) or (a)(2)(iii) because the plan has established payment rates that are less than the Original Medicare Plan, or (2) to ensure that its enrollees have access to providers who have agreed in advance to accept the plan's terms and conditions of payment. In the latter case, the plan has established payment rates that are same or higher than the Original Medicare Plan.]

This directory contains the names of providers who contract with our plan. You may pay more for services if you do not use one of these providers, except in emergencies, for certain urgently needed services, and for out-of-area dialysis services. [***Note:*** describe here what category or categories of providers Plan has under direct contract in order to meet Medicare access requirements and if the plan has established any higher cost-sharing requirements if the member obtains a covered service from a deemed provider].

Except in emergencies, providers who do not have a contract with our plan have the right to decide if they will accept our plan's terms and conditions of payment each time they see you. In emergency situations you simply seek care from the nearest available provider, the provider does not have to accept our Plan. See "Rules about using out-of-network providers to get your covered services" in Section 2 for a complete description of using out-of-network providers in a PFFS plan.

MA-PD and PDP

The Pharmacy Directory gives you a list of Plan network pharmacies.

[***Optional:*** Add detail to this paragraph with additional information about pharmacies in your Pharmacy Directory, on your website, or from Member Services.]

As a member of our Plan we will send you a complete Pharmacy Directory, which gives you a list of our network pharmacies, at least every three years, and an update of our Pharmacy Directory every year that we don't send you a complete Pharmacy Directory. You can use it to find the network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Member Services. They can also give you the most up-to-date information about changes in this Plan's pharmacy network, which can change during the year. You can also find this information on our website.

[***Note:*** Plans with combined pharmacy and provider directories can edit provider and pharmacy directory paragraphs to describe.]

MA-PD and PDP

Part D Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits (EOB) is a document you will get for each month you use your Part D prescription drug coverage. The EOB will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. [***Note:*** Plans may insert other methods for receiving an EOB besides receiving it in the mail.] An Explanation of Benefits is also available upon request. To get a copy, please contact Member Services.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

- A description of changes to the formulary that will occur at least 60 days in the future and affect the prescriptions you have gotten filled;
- A summary of your coverage this year, including information about:
  - [**Annual Deductible-**The amount paid before you start getting prescription coverage.]
  - **Amount Paid For Prescriptions**-The amounts paid that count towards your initial coverage limit.
  - **Total Out-Of-Pocket Costs that count toward Catastrophic Coverage**-The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your [deductible,] [***Note:*** Plan insert either "coinsurance" *OR* "co-payments" *OR* "coinsurance or co-payments"], and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount doesn't include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

Your monthly plan premium

[***Note:*** Plans should replace all references to 2008 Part A and Part B premium(s) with the 2009 amounts prior to printing.]

All Plan Types except PDPs

As a member of our Plan, you pay:

1) Your monthly Medicare Part B premium. Most people will pay the standard premium amount, which is [$96.40] in [2008]. (Your Part B premium is typically deducted from your Social Security payment.)

   Your monthly premium will be higher if you are single (file an individual tax return) and your yearly income is more than [$82,000], or if you are married (file a joint tax return) and your yearly income is more than [$164,000].) [***Note to plans with Part B premium reduction***

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

benefits: insert "Under our Plan, your premium is lower than the amount you would have to pay if you were not enrolled." Plans should adjust numbers in chart accordingly.]

If your Yearly Income is*		**In [2008], you pay***
File individual tax return	File joint tax return	
[$82,000 or below]	[$164,000 or below]	[$96.40]
[$82,001-$102,000]	[$164,001-$204,000]	[$122.20]
[$102,001-$153,000]	[$204,001-$306,000]	[$160.90]
[$153,001-$205,000]	[$306,001-$410,000]	[$199.70]
[Above $205,000]	[Above $410,000]	[$238.40]

*The above Part B premium amounts are for [2008] and will change for [2009]. If you pay a Part B late-enrollment penalty, this amount is higher.

[***Note to Cost plans***: Cost plan sponsors may not include statements about Part B premium reduction in the materials sent to Cost plan enrollees.]

2) Your monthly Medicare Part A premium, if necessary (most people don't have to pay this premium).

3) Your monthly premium for our Plan.

[***Note:*** If the plan has no premium and/or no supplemental coverage with a premium, delete parts of this subsection that don't apply and delete or edit the main heading and subheadings as needed for accuracy. Mention additional billing options other than monthly (e.g. quarterly.)]

[***Note***: You may use "method" or "program" to refer to payment plans, as shown in the model language, or you may substitute whatever name or label is used by the Plan.]

Your monthly premium for our Plan is listed in Section 10. [(If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits.)] If you have any questions about your Plan premiums or the payment programs, please call Member Services.

MA-PDs and PDPs

[***Note:*** Plans that don't have a monthly plan premium can delete this section. MA-PDs can reduce redundant information already provided above.]

As a member of our Plan, you pay a monthly plan premium. (Unless you qualify for full extra help, called the Low-Income Subsidy or LIS, from Medicare.)

Your monthly premium for our plan is listed in Section 10.

[If you get benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about your monthly plan premium.]

Note: If you are getting extra help (LIS) with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs". [***Note:*** If you have an SPAP in your service area, insert the following: "Or, if you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact your SPAP at the phone number listed in Section 8 to determine what benefits are available to you."] [***Note:*** Insert state-specific name of SPAP for all states in service area. "The SPAP in [insert state] is called [insert name]."]

All Plan Types

[***Note:*** Plans that don't have a monthly plan premium can delete this section.]

Monthly Plan Premium Payment Options

There are two ways to pay your monthly plan premium. [***Note:*** Indicate how the member can inform the plan of their monthly plan premium payment option choice and the procedure for changing that choice.]

Option one: Pay your monthly plan premium directly to our Plan.

You may decide to pay your monthly plan premium directly to our Plan.

[***Note:*** Insert plan specifics regarding premium payment intervals (e.g., monthly, quarterly- please note that beneficiaries must have the option to pay their premiums monthly), how they can

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

pay by check, including an address, whether they can drop off a check in person, and by what day the check must be received (e.g., the 5th of each month). If the Plan uses coupon books, explain when they will receive it and to call Member Services for a new one if they run out or lose it. In addition, include information if you charge for bounced checks.]

Instead of paying by check, you can have your monthly plan premium [Note: include all relevant choices: automatically withdrawn from your bank account, charged directly to your credit card, charged directly to your debit card]. [***Note:*** Insert plan specific information on the frequency of automatic deductions (e.g., monthly, quarterly – please note that beneficiaries must have the option to pay their premiums monthly), the approximate day of the month the deduction will be made, and how this can be set up.]

Option two: **You may have your monthly plan premium directly deducted from your monthly Social Security payment.**
Contact Member Services for more information on how to pay your monthly plan premium this way.

Note: We don't recommend this option if you are getting extra help for your monthly plan premium payment from another payer, like a State Pharmaceutical Assistance Program (SPAP). [***Insert if plan has SPAP in service area:*** (SPAPs have different names in different states. See Section 8 for the name and phone number for the SPAP in your area.)] Social Security can only withhold the full amount of the monthly plan premium and will not recognize any monthly plan premium payments made by other payers as part of this process.

MA-PDs and PDPs

Can your monthly plan premiums change during the year?

[***Note to MA-PD Plans***: Plans that don't have a monthly plan premium can delete this section.]
The monthly plan premium associated with this plan cannot change during the year. However, the amount you pay could change, depending on whether you become eligible for, or lose, extra help for your prescription drug costs. If our monthly plan premium changes for next year we will tell you in October and the change will take effect on January 1.

PRA Disclosure Statement

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and/or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a plan later. The plan will let you know what the amount is and it will be added to your monthly premium. This penalty amount changes every year, and you have to pay it as long as you have Medicare prescription drug coverage. However, if you qualified for extra help in 2006, 2007, or 2008, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2009, the national base beneficiary premium is [insert amount]). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Member Services to find out more about the late enrollment penalty reconsideration process and how to ask for such a review.

You won't have to pay a late enrollment penalty if:

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was <u>not</u> creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help AND you enroll in a Medicare prescription drug plan by December 31, 2008, AND you stay in a Medicare prescription drug plan

<u>All Plan Types</u>

[***Note:*** MA and MA-PD plans that don't have a monthly plan premium can delete this section.]

PRA Disclosure Statement

[***Note:*** Delete this subsection if the Plan doesn't take action by discontinuing or disenrolling members who fail to pay basic and optional supplemental premiums.]

What happens if you don't pay or are late with your monthly plan premiums?

If your monthly plan premiums are late [***Cost plans insert***: "or you have not been paying your [insert as appropriate: co-payments, coinsurance, or deductibles]"], we will tell you in writing that if you don't pay your monthly plan premium [***Cost plans insert***: "or [insert as appropriate: co-payments, coinsurance, or deductibles]"] by a certain date, which includes a grace period, we will end your membership in our Plan." Our plans grace period is [Insert length of plan grace period]. [***Note to PDPs:*** do not include next sentence.] If we end your membership, you will have Original Medicare Plan coverage.

[***Add if applicable***: "Should you decide later to re-enroll in our Plan, or to enroll in another plan that we offer, you will have to pay any late monthly plan premiums that you didn't pay from your previous enrollment in our Plan."]

[***Note***: If you offer optional supplemental benefits and take action for members who fail to pay the monthly plan premium for these benefits, insert "If you signed up for extra benefits ("optional supplemental benefits"), and you don't pay the additional monthly plan premium for these extra benefits on time, we will tell you in writing that if you don't pay the monthly plan premium for these extra benefits within [insert plan grace period] we will [insert either "end coverage for the extra benefits" OR "we will end your plan coverage.] If you want to terminate your extra benefits, you must notify us in advance or we will end your membership."]

MA-PDs and PDPs

What extra help is available to help pay my plan costs?

[***Note to organizations offering plans in the U.S. Territories*:** revise this section as needed to reflect the LIS program available in their service areas.]

Medicare provides "extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for any Medicare drug plan's monthly premium, [yearly

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

deductible,] and prescription co-payments. If you qualify, this extra help will count toward your out-of-pocket costs.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. **You automatically qualify for extra help and don't need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails a letter to people who automatically qualify for extra help.

2 **You apply and qualify for extra help.** You may qualify if your yearly income in 2008 is less than $[insert 2008 LIS income amount] (single with no dependents) or $[insert 2008 LIS income amount] (married and living with your spouse with no dependents), and your resources are less than $11,990 (single) or $23,970 (married and living with your spouse). These resource amounts include $1,500 per person for burial expenses. Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) or visit www.socialsecurity.gov on the Web. You may also be able to apply at your State Medical Assistance (Medicaid) office. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2008 and will change in 2009. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do costs change when you qualify for extra help?

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs".

PRA Disclosure Statement

What if you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us. [***Note:*** Insert plan's process for allowing beneficiaries to request assistance with obtaining best available evidence, and for providing this evidence.]

When we receive the evidence showing your co-payment level, we will update our system or implement other procedures so that you can pay the correct co-payment when you get your next prescription at the pharmacy. Please be assured that if you overpay your co-payment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future co-payments. Of course, if the pharmacy hasn't collected a co-payment from you and is carrying your co-payment as a debt owed 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.

All Plans

Important Information

We will send you [***Note:*** Insert name of COB Survey(s)] so that we can know what other [health and/or drug] coverage you have besides our Plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional [health and/or drug] coverage, you must provide that information to our Plan. [***MA-PDs and PDPs include:*** "The information you provide helps us calculate how much you and others have paid for your prescription drugs."] In addition, if you lose or gain additional [health and/or prescription drug] coverage, please call Member Services to update your membership records.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

2. How You Get [Care] [and] [Prescription Drugs]

All Plan Types except PDP-only [PDP info is at the end of this section]

How You Get Care

What are "providers"?

"Providers" is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed by the state and as appropriate eligible to receive payment from Medicare.

What are "network providers"?

[***Note to HMOs, PPOs, Cost plans, network PFFS plans and MSA plans with a network:*** insert "A provider is a "network provider" when they participate in our Plan. When we say that network providers "participate in our Plan," this means that we have arranged with them (for example, by contracting with them) to coordinate or provide covered services to members in our Plan. Network providers may also be referred to as "plan providers."] [***Note***: Dual eligible SNPs should indicate in their provider directory which providers are Medicaid providers. Institutionalized SNPs should indicate in their provider directory which providers also serve people in the community.]

What are "covered services"?

"Covered services" is the term we use for all the medical care, health care services, supplies, and equipment that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 10.

What do you pay for "covered services"?

The amount you pay for covered services is listed in Section 10.

All plan types except PDPs

Providers you can use to get services covered by our Plan

HMO plans

While you are a member of our Plan, you must use our network providers to get your covered services except in limited cases such as emergency care, urgently needed care when our network is not available, or out of service area dialysis. We list the providers that participate with our Plan in our provider directory. If you get non-emergency care from non-plan (out-of-network) providers without prior authorization you must pay the entire cost yourself, unless the services are urgent and our network is not available, or the services are out-of-area dialysis services. If an out-of-network provider sends you a bill that you think we should pay for emergency services, please contact Member Services or send the bill to us for payment.

HMO Plans with a Point-of-Service (POS) option

[Describe POS option here. Tell members under what circumstances they may obtain services from out-of-network providers and what restrictions apply. General information (no specific dollar amounts) about cost-sharing applicable to use of out-of-network providers in HMO/POS plans should be inserted here, with reference to benefits chart where detailed information can be found.]

All PPO Plans

We list the providers that participate with our Plan in our provider directory. While you are a member of our Plan you may use either network providers or out-of-network providers. However, your out-of-pocket costs may be higher if you use out-of-network providers, except for emergency care, urgently needed care when our network is not available, or out of area dialysis services. See Section 10 for the costs when you get services from network providers. You don't need to get a referral or prior authorization when you get care from out-of-network providers, however, before getting services from out-of-network providers you may want to confirm with us that the services you are getting are covered by us and are medically necessary. If an out-of-network provider sends you a bill that you think we should pay, please contact Member Services or send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You won't have to pay an out-of-network provider any more than what he or she would have gotten if you had been covered with the Original Medicare Plan. It is best to ask an out-of-network provider to bill us first, but if you have already paid for the covered services, we will reimburse you for our share of the cost. (Please note that we cannot pay a provider who has opted out of the Medicare program. Check with your provider before receiving services to confirm that they have not opted out of Medicare.) [If we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost.] [***Include if applicable:*** "In addition,

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

we offer a reduction in cost-sharing if you voluntarily notify us about the use of out-of-network providers."]

[***Note to regional PPOs:*** RPPOs that CMS has granted permission to use the exception in § 422.112(a) (1) (ii) to meet access requirements should insert: "Because our Plan is a Regional Preferred Provider Organization, if no contracted network provider is readily available you can access care at in-network cost-sharing from an out-of-network provider. Call Member Services to let us know you need to see an out-of-network provider, or to get help finding an out-of-network provider.]

All PFFS Plans

As a member of our Plan, you may get healthcare services from any provider, such as a doctor or hospital, in the United States who is eligible to be paid by Medicare and agrees to accept the plan's terms and conditions of payment prior to providing healthcare services to you. Not all providers may accept our plan's payment terms or agree to treat you. Therefore, you must show your plan membership ID card every time you visit a health care provider so that the provider is aware of your membership in a PFFS plan. There is a telephone number or website on the card for the provider to find out about our plan's terms and conditions of payment. This gives your provider the right to choose whether to accept our plan's terms and conditions of payment before treating you. The provider cannot change his/her mind about accepting the Plan's terms and conditions of payment after furnishing services. If you need emergency care, it is covered whether the provider agrees to accept the plan's payment terms or not.

If your provider agrees to accept our plan, then the provider must follow the plan's terms and conditions for payment, and bill the plan for the services they provide for you. You are only required to pay the copayment or coinsurance amount allowed by our plan at the time of the visit. A provider can decide at every visit whether or not to accept our plan's payment terms and agree to treat you.

As soon as you have told your provider that you are a member of our Plan (for example, by showing them your plan ID card) and they agree to treat you, your provider is bound by the terms and conditions of payment of the Plan even if they don't explicitly accept them. We call these providers "deemed providers".

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

If your provider doesn't agree to our plan's terms and conditions of payment, then the provider shouldn't provide services to you, except for emergencies. In this case, you will need to find another provider that will accept our plan's payment terms. If the provider chooses to treat you, then they may not bill you. They must bill the plan for your covered health care services. You are only required to pay the copayment or coinsurance amount allowed by the plan and listed in Section 10 at the time of the service.

[***Note to Network PFFS***: adapt the following language for the network PFFS plan that is being offered: "Our Plan has direct contracts with some providers to provide you with health care services."] [***Note*:** Plan should describe what category or categories of providers it has under direct contract that were approved by CMS and whether or not the Plan has established any higher cost-sharing requirement if the member obtains a covered service from a deemed provider. Insert the following sentence if the plan includes such differential cost-sharing: "Note that the amount of cost-sharing you pay a non-contracted provider may be more than the cost-sharing you pay a contracted provider."]

What should you do with your provider bills?

You should only pay the provider the cost-sharing allowed by our Plan and listed in Section 10. You should ask your provider to bill us for the rest of the fee and we will pay the provider according to our Plan's terms and conditions of payment. If the provider asks you to pay the full amount of the bill, and have you get paid back by the Plan, tell the provider that you only have to pay the cost-sharing amount. Your membership card in our Plan will indicate how the provider can contact us for information on our terms and conditions of payment. If the provider wants further information on payment for covered services, please have them contact us at [***Note:*** insert instructions that include a phone number and mailing address].

If you get a bill for the services, you may send the bill to us for payment. We will pay your provider for our share of the bill and will let you know if you must pay any cost-sharing. However, if you have already paid for the covered services we will reimburse you for our share of the cost.

If you have any questions about whether our plan will pay for a certain health care service, you can ask us for a written advance coverage decision before you get the service. We will let you know if our plan will pay for the service.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

MSA Plans

You are free to use any Medicare-qualified provider who agrees to provide you with services, both before and after you meet the deductible. Prior to meeting your deductible, if you receive covered services [from out-of-network providers] and you pay your bill at the time of service, you must submit a claim to our Plan so that we can count it towards your deductible and your Plan maximum out-of-pocket limit. After you meet the deductible, we will pay for services. If you need assistance submitting a paper claim, please call Member Services.

You have the right to make a complaint (called an appeal) about decisions regarding whether your expenses, paid for with money from your MSA Bank Account or paid for out of pocket, constitute Medicare expenses that count towards the plan deductible. You may also appeal if you believe that, prior to meeting the deductible, you have been required to pay more for a service than the Medicare allowable amount. See Section 5 for more information on how to file an appeal.

MSAs and drug coverage

The law does not allow Medicare Advantage Medical Savings Account (MSA) Plans to offer Medicare Part D prescription drug coverage. If you have a Medicare MSA Plan, you can, however, also join a Medicare Prescription Drug Plan to get Part D coverage. Any money that you use from your MSA savings account on [drug plan deductibles or] cost sharing will NOT count towards your MSA plan deductible, but it will count towards your drug plan's out-of-pocket costs. If you are interested in enrolling in a Medicare prescription drug plan or to see what plans are available in your area, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Generally, unless you are new to Medicare or meet a special exception, you can only join during the Medicare fall open enrollment period, which occurs from November 15-December 31 of each year.

Note that even if you are not enrolled in a Medicare prescription drug plan, money spent from your MSA savings account on prescription and non-prescription drugs are considered "qualified medical expenses" for tax-reporting purposes and are not taxed. See the discussion on tax-reporting responsibilities for members of MSAs in Section 3 for more information on qualified medical expenses.

PRA Disclosure Statement

All Cost Plans

If you get original Medicare services from an out-of-network provider then you must pay the original Medicare cost-sharing amounts - except in an emergency or if the services were urgently needed. You can find the original Medicare cost-sharing amounts in the *Medicare & You* handbook or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. [***Note:*** insert this sentence if your plan offers supplemental benefits: "If you get covered supplemental benefits, such as [include examples of supplemental benefits], from an out-of-network provider then you must pay the entire cost of the service."] If an out-of-network provider sends you a bill that you think we should pay, please contact Member Services. Generally, it is best to ask an out-of-network provider to bill the Original Medicare Plan first, and then to bill us for the remaining amount. We may require the out-of-network provider to bill the Original Medicare Plan. We will then pay any applicable Medicare coinsurance and deductibles minus your co-payments on your behalf. Note: If we do not cover services furnished by an out-of-network provider, the services will be covered by Original Medicare if they are Medicare-covered services. In this case you would be responsible for Original Medicare cost-sharing amounts.

All plans except PDP

Choosing Your [Primary Care Physician (PCP)/Physician of Choice]

[***Note***: Insert this section only if plan uses PCPs. (Replace PCP with POC, if applicable.) If plan uses PCPs, explain PCP in context of your plan type by including at least the following:

- What is a PCP?
- What types of providers may act as a PCP?
- How do you choose/change a PCP if member desires or when PCP leaves plan?
- Explain the role of a PCP in your plan.
- What services does the PCP furnish (e.g. routine medical care) and what services can members get on their own? Be sure to include the following services that Medicare beneficiaries can get on their own without approval in advance:
    - Routine women's health care, which include breast exams, mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
    - Flu shots [***Note*:** insert if appropriate: "and pneumonia vaccinations"] [***Note*:** insert if appropriate: "as long as you get them from a network provider"].

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

- Emergency services, whether you get these services from network providers or out-of-network providers
- Urgently needed care that you get from out-of-network providers when you are temporarily outside the Plan's service area or when you are in the service area but, because of unusual or extraordinary circumstances, the Network providers are temporarily unavailable or inaccessible.
- Dialysis (kidney) services that you get at a Medicare certified dialysis facility when you are temporarily outside the Plan's service area. [***Note:*** You may insert requests here, e.g., if possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.] [***Note to Cost plans***: delete this bullet.]

- What is the role of the PCP in coordinating covered services?
- For what services will the PCP need to get prior authorization from the plan?
- Explain if the selection of a PCP results in being limited to specific specialists or hospitals to which that PCP refers, i.e. sub-network, referral circles.

All MA plans except non-network PFFS and non-network MSAs

What if your doctor or other provider leaves your plan?

Sometimes a network provider you are using might leave the Plan. If this happens, you will have to switch to another provider who is part of our Plan [***PPOs with lower cost-sharing for network providers insert:*** "or you will pay more for covered services"]. Member Services can assist you in finding and selecting another provider.

[***Note to SNP Plans:*** Organizations offering dual eligible SNPs that are obligated under state Medicaid programs to have a transition benefit when a doctor leaves a plan, may discuss that benefit here.]

All Plan Types except PDP

Getting care if you have a medical emergency or an urgent need for care

[***Note***: Throughout this section plans can change "notify plan" to provider, medical group or any other specific area the member should call after an emergency.]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

What is a "medical emergency"?

A "medical emergency" is when you believe that your health is in serious danger. A medical emergency includes severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. You don't need to get approval or a referral first from your doctor or other network provider.
- As soon as possible, make sure that we know about your emergency, because we need to be involved in following up on your emergency care. [***Note to HMO and Cost Plans:*** insert **"**You or someone else should call to tell us about your emergency care, usually within 48 hours."] [*Note***:** Insert instructions – either give the number to call or explain where to get the number to call (e.g., the back of the membership card)].]

[***Note to all plan types except PDPs, PFFS and MSAs*:** include next paragraph and modify accordingly to address post-stabilization care for your plan type.]

We will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over then you are still entitled to follow-up post stabilization care. Your follow-up post stabilization care will be covered according to Medicare guidelines. In general, if your emergency care is provided out of network we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You may get covered emergency medical care whenever you need it, anywhere in the United States. [***Note to MA-PD*:** insert "We discuss filling prescriptions when you cannot access a network pharmacy later in this section."]
- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health. (See the benefits chart in Section 10 for more detailed information.)
- [***Note*:** If the plan offers supplemental benefit covering emergencies or ambulance services outside of the country, then refer members to

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Section 10 for more information.]

What if it wasn't a medical emergency?

HMOs, PPOs, and Cost Plans

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'" above. [***HMO and Cost plans:*** include "If you get any extra care after the doctor says it wasn't a medical emergency, the Plan will pay its portion of the covered additional care **only if you get it from a network provider."** [***HMO plans:*** include "We will pay our portion of the covered additional care from an out-of-network provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below."][***Cost plans:*** include "If you get any extra care from an **out-of-network** provider after the doctor says it wasn't a medical emergency, you will normally have to pay the Original Medicare Plan cost-sharing. "] [***PPO plans:*** include "If you get any extra care after the doctor says it wasn't a medical emergency, the amount of cost-sharing that you pay will depend on whether you get the care from network providers. If you get the care from network providers, your costs will usually be lower than if you get the care from out-of-network providers."]

All PFFS Plans

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it was not a medical emergency after all. If you decide to get follow-up care from the provider treating you, then you should advise them of your plan enrollment as soon as possible, for example by showing them your member ID card with your plan information. The plan will pay for all medically necessary plan covered services furnished by the provider and non-emergency care that you get from any provider in the United States to whom you have informed, by showing your member ID card, that you are a plan member, and who agrees to accept our plan's terms and conditions of payment. [***Note to PFFS plans with Part D coverage:*** include "(There is more information later in this section on filling your prescription drugs when you are getting urgently needed care and when you are outside the Plan's service area.)"]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

HMOs, PPOs, and Cost Plans and network MSAs

What is urgently needed care?

Urgently needed care refers to a non-emergency situation when you are:

- Inside the United States [***Note:*** Plans with a supplemental benefit providing emergency coverage out of the country can indicate it here and refer members to Section 10 for more information.]
- Temporarily absent from the Plan's authorized service area
- In need of medical attention right away for an unforeseen illness, injury, or condition**,** and
- It isn't reasonable given the situation for you to obtain medical care through the Plan's participating provider network.

Under unusual and extraordinary circumstances, care may be considered urgently needed and paid for by our Plan when the member is in the service area, but the provider [PPOs may replace "provider" with "preferred"] network of the Plan is temporarily unavailable or inaccessible.

What is the difference between a "medical emergency" and "urgently needed care"?

The two main differences between urgently needed care and a medical emergency are in the danger to your health and your location. A "medical emergency" occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the service area. "Urgently needed care" is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger and you are generally outside of the service area.

How to get urgently needed care

If, while temporarily outside the Plan's service area, you require urgently needed care, then you may get this care from any provider. The plan is obligated to cover all out-of-area urgently needed care at the same cost-sharing levels that apply to care received within the Plan network.

Note: If you have a pressing, non-emergency medical need while in the service area, you generally must obtain services from the Plan according to its procedures and requirements as outlined earlier in this section.

PRA Disclosure Statement

PFFS Plans

What is urgently needed care?

Urgent care refers to non-emergency care received outside the service area of the Plan. However, as discussed in detail earlier in this section, a PFFS plan allows enrollees to access care from any Medicare-approved provider in the United States who agrees to accept our plan's terms and conditions of payment prior to treating you. Consequently, the concept of urgent care does not apply, since you may always obtain care outside of the service area. [Note: insert "Plans with a supplemental benefit providing emergency coverage out of the country should indicate it here."]

Non-network MSA plans

What is urgently needed care?

Urgent care refers to non-emergency care received outside the service area of the Plan. A MSA plan allows enrollees to access care from any Medicare-approved provider in the United States who agrees to treat you. Consequently, the concept of urgent care does not apply, since you may always obtain care outside of the service area.

All MA Plan Types except Cost plans

What is your cost for services that aren't covered by our Plan?

Our Plan covers all of the medically-necessary services that are covered under Medicare Part A and Part B. Our Plan uses Medicare's coverage rules to decide what services are medically necessary. You are responsible for paying the full cost of services that aren't covered by our Plan. Other sections of this booklet describe the services that are covered under our Plan and the rules that apply to getting your care as a plan member. Our plan might not cover the costs of services that aren't medically necessary under Medicare, even if the service is listed as covered by our Plan.

If you need a service that our Plan decides isn't medically necessary based on Medicare's coverage rules, you may have to pay all of the costs of the service if you didn't ask for an advance coverage determination. However, you have the right to appeal the decision.

If you have any questions about whether our Plan will pay for a service or item, including inpatient hospital services, you have the right to have an organization determination [or a coverage determination] made for the service. You may call Member Services and tell us you would like a decision on whether the service will be covered before you get the service.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service [***Note*:** Explain whether paying for costs once a benefit limit has been reached will count toward an out-of-pocket maximum.] You can call Members Services when you want to know how much of your benefit limit you have already used.

Cost Plans

What is your cost for services that are not covered by Medicare or our Plan

You are responsible for paying for the full cost of care and services that aren't covered by the Original Medicare Plan or our Plan. Other sections of this EOC describe the services that are covered by our Plan and the rules that apply to getting your care as a plan member. You also have the right to seek care from any provider that is qualified to treat Medicare members. However, in that case it will be the original Medicare program that pays your claims and you will owe the Original Medicare Plan cost-sharing amounts.

If you have any question whether Medicare or our Plan will pay for a service, including inpatient hospital services, you have the right under law to have a written/binding advance coverage determination made for the service. Call our Plan and tell us you would like a decision if the service or item will be covered by our Plan.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service, unless your plan offers, as a covered supplemental benefit, coverage beyond the Original Medicare Plan limits. [Explain whether paying for costs once a benefit limit has been reached will count toward an out-of-pocket maximum.]

You can call Member Services when you want to know how much of your benefit limit you have already used.

PRA Disclosure Statement

How can you participate in a clinical trial?

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

The Original Medicare Plan pays for routine costs if you take part in a clinical trial that meets Medicare requirements (meaning it's a "qualified" clinical trial and Medicare-approved). Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care, like diagnostic services, follow-up care, and care that is unrelated to the clinical trial through our Plan. Our Plan is still responsible for coverage of certain investigational devices exemptions (IDE), called Category B IDE devices, needed by our members.

[***Note:*** If your plan charges the Original Medicare cost-sharing amounts for clinical trial services, use this language: "You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive when participating in a qualifying clinical trial, but you do not have to pay the Original Medicare Part A or Part B deductibles because you are enrolled in our Plan."]

[***Note:*** If you will cover all or a portion of the FFS coinsurance for your members participating in a clinical trial, say so here and/or modify the previous sentences. Also, specify the conditions (if any) under which such additional coverage is available (e.g., if the member participates in a clinical trial sponsored by one of your contracting providers.)]

You don't need to get a referral (approval in advance) from a network provider to join a clinical trial, and the clinical trial providers don't need to be network providers. However, please be sure

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know whether the clinical trial is Medicare-approved, and what services you will get from clinical trial providers instead of from our plan.

You may view or download the publication "Medicare and Clinical Trials" at www.medicare.gov under "Search Tools" select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How to access care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or skilled nursing facility care. You may get services furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) [***Note***: Plans that do not require authorization, delete the following sentence.] Your stay in the RNHCI is not covered by our Plan unless you obtain authorization (approval) in advance from our Plan. [***Note:*** Explain whether Medicare Inpatient Hospital coverage limits apply (reference Benefits Chart) or whether there is unlimited coverage for this benefit.]

MA-PDs and PDPs

How you get prescription drugs

What do you pay for covered drugs?

The amount you pay for covered drugs is listed in Section 10.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

If you have Medicare and Medicaid

Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you qualify for Medicaid benefits.

[Note: If you have an SPAP in your service area, insert the following paragraph]

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in an SPAP, you may get help paying your [premiums,] [deductibles,] [and] [or] [cost-sharing]. Please contact your SPAP to determine what benefits are available to you. SPAPs have different names in different states. See Section 8 for the name and phone number for the SPAP in your area.

What drugs are covered by this Plan?

What is a formulary?

A formulary is a list of the drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described later in this section under "Utilization Management."

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. Both brand-name drugs and generic drugs are included on the formulary. A generic drug is a prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs..

Not all drugs are covered by our plan. In some cases, the law prohibits Medicare coverage of certain types of drugs. (See Section 10 for more information about the types of drugs that are not normally covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug on our formulary.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See information later in this section about filling a prescription at an out-of-network pharmacy.

How do you find out what drugs are on the formulary?

Each year, we send you an updated formulary so you can find out what drugs are on our formulary. You can get updated information about the drugs our Plan covers by visiting our Website. You may also call Member Services to find out if your drug is on the formulary or to request an updated copy of our formulary.

[What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your [***Note:*** Plan insert either: "coinsurance" OR "co-payment" OR "coinsurance or co-payment"] depends on which drug tier your drug is in.

You may ask us to make an exception (which is a type of coverage determination) to your drug's tier placement. See Section 5 to learn more about how to request an exception.]

[MA-PD and PDPs that use reference based pricing, insert following paragraph.]

[What is reference based pricing?

Our plan uses reference based pricing for certain drugs on our formulary. [***Note:*** Plans should describe approach to reference based pricing and its resultant impact on cost-sharing or co-insurance.] Please see our abridged or comprehensive formulary for a list of those formulary drugs impacted by reference based pricing. You can call Member Services for more information on reference based pricing and the impact it may have on drugs you are taking.]

Can the formulary change?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug
- [Moving a drug to a higher or lower cost-sharing tier]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

If we remove drugs from the formulary, [or add prior authorizations, quantity limits and/or step therapy restrictions on a drug] [or move a drug to a higher cost-sharing tier] and you are taking the drug affected by the change, you will be permitted to continue taking that drug [at the same level of cost-sharing] for the remainder of the Plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60 day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an exception. (If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug immediately and notify members taking the drug about the change as soon as possible.)

What if your drug isn't on the formulary?

If your prescription isn't listed on your copy of our formulary, you should first check the formulary on our website which we update at least monthly. In addition, you may contact Member Services to be sure it isn't covered. If Member Services confirms that we don't cover your drug, you have two options:

1. You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Member Services or go to our formulary on our website.
2. You or your doctor may ask us to make an exception (a type of coverage determination) to cover your drug. If you pay out-of-pocket for the drug and request an exception that we approve, the Plan will reimburse you. If the exception isn't approved, you may appeal the Plan's denial. See Section 5 for more information on how to request an exception or appeal.

In some cases, we will contact you if you are taking a drug that isn't on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

If you recently joined this Plan, you may be able to get a temporary supply of a drug you were taking when you joined our Plan if it isn't on our formulary.

PRA Disclosure Statement

Transition Policy

New members in our Plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. See Section 5 under "What is an exception?" to learn more about how to request an exception. Please contact Member Services if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year and you need help switching to a different drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first [must be at least 90] days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will [***Note:*** Plan insert either "provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first [must be at least 90] days of the new plan year" OR "provide you with the opportunity to request a formulary exception in advance for the following year"].

When a member goes to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a [must be at least 30]-day supply (unless the prescription is written for fewer days). After we cover the temporary [must be a least 30]-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary [must be at least 31]-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first [must be at least 90] days a new member is enrolled in our Plan. If the resident has been enrolled in our Plan for more than [must be at least 90] days and needs a drug that isn't on our formulary [or is subject to other restrictions, such as step therapy or dosage limits,] we will cover a temporary

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

[must be at least 31]-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

[***If applicable***: Plans must insert their transition policy for current members with level of care changes.]

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access. See Section 10 for information about non-Part D drugs.

Drug Management Programs

[***Note:*** Section below applies to all plans except PFFS plans that do not have utilization management programs.]

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. Please consult your copy of our formulary or the formulary on our website for more information about these requirements and limits.

The requirements for coverage or limits on certain drugs are listed as follows:

[**Prior Authorization**: We require you to get prior authorization (prior approval) for certain drugs. This means that your provider will need to contact us before you fill your prescription. If we don't get the necessary information to satisfy the prior authorization, we may not cover the drug.]

[**Quantity Limits**: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to [number of units] per [defined prescription period (i.e., per 30-day period)] for a formulary drug.]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

[**Step Therapy**: In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.]

[**Generic Substitution**: When there is a generic version of a brand-name drug available, our network pharmacies may recommend and/or provide you the generic version, unless your doctor has told us that you must take the brand-name drug and we have approved this request.]

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary or on our website, or by calling Member Services. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). See Section 5 for more information about how to request an exception.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Medication therapy management programs

[***Note:*** The section below applies to all plans except PFFS plans that do not have MTM programs.]

We offer medication therapy management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

PDP Only

Your enrollment in this Plan doesn't affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan. In addition, if your drug would be covered by Medicare Part A or Part B, it can't be covered by us even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part B in some cases and through this Plan (Medicare Part D) in other cases but never both at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or us for the drug in question.

See your *Medicare & You* handbook for more information about drugs that are covered by Medicare Part A and Part B. The Medicare & You handbook can also be found on www.medicare.gov or you can request a copy by 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

MA-PDs

We cover drugs under both Parts A and B of Medicare, as well as Part D. The Part D coverage we offer doesn't affect Medicare coverage for drugs that would normally be covered under Medicare Part A or Part B. Depending on where you may receive your drugs, for example in the doctor's office versus from a network pharmacy, there may be a difference in your cost-sharing for those drugs. You may contact our Plan about different costs associated with drugs available in different settings and situations.

MA-PDs and PDPs

If you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our Plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and adjust your premium.

Each year (prior to November 15), your Medigap insurance company must send you a letter explaining your options and whether the prescription drug coverage you have is creditable (whether it expects to pay, on average, at least as much as Medicare's standard prescription drug coverage) and how the removal of drug coverage from your Medigap policy will affect your premiums. If you didn't get this letter or can't find it, you have the right to get a copy from your Medigap insurance company.

If you are a member of an employer or retiree group

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage.

Each year (prior to November 15), your employer or retiree group should provide a disclosure notice to you that indicates if your prescription drug coverage is creditable (meaning it expects to pay, on average, at least as much as Medicare's standard prescription drug coverage) and the options available to you. You should keep the disclosure notices that you get each year in your

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

personal records to present to a Part D plan when you enroll to show that you have maintained creditable coverage. If you didn't get this disclosure notice, you may get a copy from the employer's or retiree group's benefits administrator or employer/union.

Using network pharmacies to get your prescription drugs

With few exceptions, which are noted later in this section under "How do you fill prescriptions outside the network?", **you must use network pharmacies to get your prescription drugs covered.** A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term "covered drugs" means all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in our formulary.

In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You aren't required to always go to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy than the one you have previously used, you must [either have a new prescription written by a doctor or] have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain. To find a network pharmacy in your area, please review your Pharmacy Directory. You can also visit our website or call Member Services.

What is a Preferred Pharmacy?

Preferred pharmacies are pharmacies in our network in which our Plan has negotiated lower cost-sharing for its plan members for covered prescription drugs than at [Note: Insert either "non-preferred pharmacies" or "other network pharmacies".] However, you will still have access to lower drug prices at [Note: Insert either "non-preferred pharmacies" or "these other network pharmacies"] than at out-of-network pharmacies. You may go to either of these types of network pharmacies to receive your covered prescription drugs. [Note: Describe restrictions imposed on members that use non-preferred pharmacies.]

What if a pharmacy is no longer a network pharmacy?

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Member Services to find another network pharmacy in your area.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

How do you fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you don't have your membership card with you when you fill your prescription, you may have the pharmacy call [network pharmacy contact information] to obtain the necessary information. If the pharmacy is unable to obtain the necessary information, you may have to pay the full cost of the prescription. If you pay the full cost of the prescription (rather than paying just your [Note: plan insert either "coinsurance" OR "co-payment" OR "coinsurance or co-payment"]) you may ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?"

How do you fill a prescription through our Plan's network mail-order-pharmacy service?

[***Note:*** delete this section if plan does not offer mail-order pharmacy service.]

[***Note:*** Include the following language only if your mail-order service is limited to a subset of all formulary drugs, adapting terminology as needed: "You can use our network mail-order service[s] to fill prescriptions for some drugs. [These drugs are marked as [***Note:*** Insert either "maintenance" *OR* "mail-order"] drugs on the formulary list.] [These are drugs that you take on a regular basis, for a chronic or long-term medical condition.] The formulary list tells you which drugs are available through our mail-order service[s]."]

When you order prescription drugs through our network mail-order-pharmacy service, you [***Note:*** Plan insert either "must order at least a [xx]-day supply, and no more than a [xx]-day supply" *OR* "may order up to a [xx] day supply"] of the drug.

Generally, it takes the mail-order pharmacy [xx] days to process your order and ship it to you. However, sometimes your mail-order may be delayed. *[**Note**:* Insert Plan's process for members to get a prescription if the mail-order is delayed.]

You are not required to use mail-order prescription drug services to obtain an extended supply of [maintenance]/[mail-order] medications. Instead, you have the option of using [***Note:*** Plan insert either "a preferred retail pharmacy" OR "a non-preferred retail pharmacy" OR "another network retail pharmacy"] in our network to obtain a supply of [maintenance/mail-order] medications.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Some of these retail pharmacies [may] agree to accept the mail-order cost-sharing amount for an extended supply of [maintenance/mail-order] medications, which may result in no out-of-pocket payment difference to you. [Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for an extended supply of [maintenance/mail-order] medications. In this case, you will be responsible for the difference in price.] Your Pharmacy Directory contains information about retail pharmacies in our network at which you can obtain an extended supply of [maintenance/mail-order] medications. You can also call Member Services for more information.

To get [order forms and] information about filling your prescriptions by mail, [*Note:* insert instructions]. Please note that you must use our network mail-order service[s]. Prescription drugs that you get through any other mail-order services are not covered.

How do you fill prescriptions outside the network?

[We have network pharmacies outside of the service area where you can get your drugs covered as a member of our Plan.] Generally, we only cover drugs filled at an out-of-network pharmacy in limited, non-routine circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill your prescription in these situations, call Member Services to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just [Note: plans insert either "coinsurance" OR "co-payment" OR "coinsurance OR co-payment"]) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay for a covered Part D drug will help you qualify for catastrophic coverage. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?" [If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-network pharmacy.]

[***Note:*** Plans should insert a list of situations when they will cover prescriptions out of the network 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.)]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

How do you submit a paper claim?

You may submit a paper claim for reimbursement of your drug expenses in the situations described below:

- **Drugs purchased out-of-network.** When you go to a network pharmacy and use our membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed in the section above ("How do you fill prescriptions outside the network?), the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription and submit a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

- **Drugs paid for in full when you don't have your membership card.** If you pay the full cost of the prescription (rather than paying just your [***Note:*** plan insert either "coinsurance" OR "co-payment" OR "coinsurance or co-payment"]) because you don't have your membership card with you when you fill your prescription, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

- **Drugs paid for in full in other situations.** If you pay the full cost of the prescription (rather than paying just your [***Note:*** plan insert either "coinsurance" OR "co-payment" OR "coinsurance or co-payment"]) because it is not covered for some reason (for example, the drug is not on the formulary or is subject to coverage requirements or limits) and you need the prescription immediately, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. In these situations, your doctor may need to submit additional documentation supporting your request. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

- **If you are retroactively enrolled in our Plan because you were Medicaid eligible.** As discussed in the section below ("Reimbursing plan members for coverage during retroactive periods"), you must submit a paper claim in order to be reimbursed for out-of-pocket expenses you had during this time period (and that were not reimbursed by other

PRA Disclosure Statement

insurance). This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

- **Drugs purchased at a better cash price**. In rare circumstances when you are in a coverage gap or deductible period and have bought a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

- **Copayments for drugs provided under a drug manufacturer patient assistance program**. If you get help from, and pay co-payments under, a drug manufacturer patient assistance program outside our Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

- [***Note:*** Insert additional circumstances under which you will accept paper claims from enrollees]

You may ask us to reimburse you for our share of the cost of the prescription by sending a written request to us. [***Note:*** If the plan has developed a specific form for requesting reimbursement, insert the following language "Although not required, you may use our reimbursement claim form to submit your written request. You can get a copy of our reimbursement claim form on our website or by calling Member Services**. Please include your receipt(s) with your written request.**

Please send your written reimbursement request to [***If the plan processes enrollee-submitted reimbursement requests in the same location that it processes all other coverage determination requests, insert:*** "the address listed under **Part D Coverage Determinations** in Section 8."] OR [***If the plan does not process enrollee-submitted reimbursement requests in the same location that it processes all other coverage determination requests, insert:*** "the address listed under **Part D Reimbursement Requests** in Section 8."]

[***Note to PDPs eligible to receive autoenrollments:*** include following paragraph:

"Reimbursing Plan Members for Coverage during Retroactive Periods

If you were automatically enrolled in our Plan because you were Medicaid eligible, your enrollment in our Plan may be retroactive to when you became eligible for Medicaid. Your

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

enrollment date may even have occurred last year. In order to be reimbursed for expenses you had during this time period (and that were not reimbursed by other insurance), you must submit a paper claim to us. (See "How do you submit a paper claim") We have a seven-month special transition period that allows us to cover most of your claims from the effective date of your enrollment to the current time; however, depending upon your situation, you or Medicare may be responsible for any out-of-network or price differences. You may also be responsible for some claims outside of the seven-month special transition period if the claims are for drugs not on our formulary. For more information, please call Member Services."]

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, [***Note:*** Insert if plan is a PDP **"**Medicare Part A"] [***Note:*** Insert if plan is an MA-PD "our Plan's medical (Part C) benefit"] should generally cover the cost of your prescription drugs while you are in the hospital. [***Note:*** Insert if plan is a PDP: "Once you are released from the hospital, we will cover your prescription drugs as long as the drugs meet all coverage requirements (such as the drugs being on our formulary, filled at a network pharmacy, etc.) and they aren't covered by Medicare Part A or Part B."] [***Note:*** Insert if plan is an MA-PD "Once you are released from the hospital, our plan's Part D benefit will cover your prescription drugs as long as the drugs meet all coverage requirements (such as the drugs being on our formulary, filled at a network pharmacy, etc.) and they aren't covered by our medical benefit (Part C)."] We will also cover your prescription drugs if they are approved under the Part D coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay: [***Note:*** Insert if plan is a PDP "After Medicare Part A stops paying for your prescription drug costs as part of Medicare-covered skilled nursing facility stay, we will cover your prescription drugs as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network and that the drugs aren't otherwise covered by Medicare Part B."] [***Note:*** Insert if plan is an MA-PD "After our plan's medical benefit (Part C) stops paying for your prescription drug costs as part of a Medicare-covered skilled nursing facility stay, our plan's Part D benefit will cover your prescription drugs as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network, unless you meet standards for out-of–network care, and that the drugs aren't otherwise covered by our plan's medical benefit (Part

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

C).”] When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Advantage Plan, Prescription Drug Plan, or the Original Medicare Plan. See Section 6 for more information about leaving this Plan and joining a new Medicare Plan.

Long-term care (LTC) pharmacies

Generally, residents of a long-term-care facility (like a nursing home) may get their prescription drugs through the facility’s LTC pharmacy or another network LTC pharmacy. Please refer to your Pharmacy Directory to find out if your LTC pharmacy is part of our network. If it isn’t, or for more information, contact Member Services. [***Note:*** Insert any additional information on Long-term Care pharmacy services in Plan’s network.]

[***Note:*** Insert the following section if the service area and the network contain I/T/U Pharmacies.]

Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through our Plan’s pharmacy network. Others may be able to use these pharmacies under limited circumstances (e.g., emergencies). [*Note*: Insert any additional information on I/T/U pharmacy services in Plan’s network.] Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, contact Member Services.

Home infusion pharmacies

[***Note****:* Plans may provide information on home infusion pharmacy services in their network.] Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, contact Member Services.

Some vaccines and drugs may be administered in your doctor’s office

We may cover vaccines that are preventive in nature and aren’t already covered by [Medicare Part B/our Plan’s medical benefit (Part C)]. This coverage includes the cost of vaccine administration. See Section 10 for more information about your costs for covered vaccinations.

PRA Disclosure Statement

3. Your Rights and Responsibilities as a Member of our Plan

All Plan Types

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or your local Office for Civil Rights.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. [***Note to MA-PDs and PDPs***: include "The Plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations."]

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services.

All MA plans except non-network PFFS and non-network MSA plans

Your right to [see network providers, get covered services, and] [get your prescriptions filled] within a reasonable period of time

[***Note to HMO and Cost Plans***: insert "As explained in this booklet, you will get most or all of your care from network providers, that is, from doctors and other health providers who are part of our Plan.][***Note to PPO plans:*** insert "As explained in this booklet, you can get your care from network doctors and other health providers who are part of our Plan. You can also get care from non-network doctors and other health providers who are not part of our Plan.] [***Note to PPOs:*** If your plan does not require any referrals or prior authorization within the preferred network, delete the next two sentences and instead state "You have the right to choose a provider for your care."] [You have the right to choose a network provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist [***HMOs insert:*** "in our Plan"] (such as a gynecologist) without a referral] [***Note to PPO plans:*** insert "and still pay in-plan cost-sharing"]. [You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time.] [***Note to Regional PPO plans***: explain how members will obtain care at in-plan rates in any areas of its region where the plan has a limited contracted provider network.]

All PFFS Plans

As explained in this booklet, you will get most or all of your care from licensed providers who have agreed to accept our plan's terms and conditions of payment and treat you. You have the

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

right to seek care from any provider in the U.S. who is eligible to be paid by Medicare and agrees to accept our Plan's terms and conditions of payment. You have the right to timely access to providers. "Timely access" means that you can get services within a reasonable amount of time.

PDP & MA-PD Plans

You have the right to timely access to your prescriptions at any network pharmacy.

All Plan Types except PDP

Your right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. [***Insert if applicable:*** "This includes the right to know about the different Medication Therapy Management Programs we offer and in which you may participate."] You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination [or a coverage determination]. Organization determinations [and coverage determinations] are discussed in Section 5.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

All Plan Types

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. [***Note:*** You can list your organization as a contact if they provide these forms]. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with [***Note:*** List appropriate state-specific agency

PRA Disclosure Statement

here, such as State Department of Health.] [***Note:*** Plans that would like to provide members with state specific information about advanced directives here may do so.]

All Plan Types

Your right to get information about our Plan

You have the right to get information from us about our Plan. This includes information about our financial condition, and how our Plan compares to other health plans. [Cost plans delete ", and how our Plan compares to other health plans".] To get any of this information, call Member Services.

Your right to get information in other formats

You have the right to get your questions answered. Our plan must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your plan based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your right to get information about our network [pharmacies and/or providers]

You have the right to get information from us about our network [pharmacies,] [providers and their qualifications and how we pay our doctors]. [Cost plans can delete "and their qualifications"] To get this information, call Member Services.

Your right to get information about your [prescription drugs,] [Part C medical care or services,] and costs

You have the right to an explanation from us about any [prescription drugs,] [Part C medical care or service] not covered by our Plan. We must tell you in writing why we will not pay for or approve a [prescription drug,] [Part C medical care or service,] and how you can file an appeal to ask us to change this decision. See Section 5 for more information about filing an appeal. You also have the right to this explanation even if you obtain the [prescription drug,] [Part C medical care or service] from a [pharmacy and/or provider] not affiliated with our organization. [You also have the right to receive an explanation from us about any utilization-management

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

requirements, such as step therapy or prior authorization, which may apply to your plan. Please review our formulary website or call Member Services for more information.]

All Plan Types

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your [***Insert either*** "coverage" OR "care" OR "coverage or care".] See Section 4 and Section 5 for more information about complaints. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services.

[Plans may insert custom privacy practices.]

How to get more information about your rights

If you have questions or concerns about your rights and protections, you can

1. Call Member Services at the number on the cover of this booklet.
2. Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Section 8 of this booklet.
3. Visit www.medicare.gov to view or download the publication "Your Medicare Rights & Protections."
4. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call Member Services or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

All Plan Types

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Member Services if you have questions.
- ***[MSA Plans do not include this bullet.]*** Using all of your insurance coverage. If you have additional [health insurance coverage *OR* prescription drug coverage] besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your [health care *OR* prescription drug] expenses. This is called "coordination of benefits" because it involves coordinating all of the [health *OR* drug] benefits that are available to you.
- **You are required to tell our Plan if you have additional [health insurance or drug coverage]. Call Member Services.**
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan enrollment card to the provider. [***Note to Cost plans:*** use "Notifying out-of-network providers when seeking care (unless it is an emergency) that although you are enrolled in our Plan, the provider should bill original Medicare. You should present your plan enrollment card and your Medicare card."]
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- Paying your [plan premiums and] [coinsurance/co-payment/coinsurance or co-payment] for your covered services. You must pay for services that aren't covered.
- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services.

PRA Disclosure Statement

What can you do if you think you have been treated unfairly or your rights aren't being respected?

For concerns or problems related to your Medicare rights and protections described in this section, you may call Member Services. You can also get help from your State Health Insurance Assistance Program, or SHIP.

MSA Plans

Special tax-reporting responsibilities of members of a Medicare Medical Savings Account (MSA)

Our Plan is a Medicare Medical Savings Account plan. MSA enrollees must file Form 1040, U.S. Individual Income Tax Return, along with Form 8853, "Archer MSAs and Long-Term Care Insurance Contracts," to the Internal Revenue Service (IRS) for any year distributions are made from their Medicare MSA account to ensure that they are not taxed on their MSA account withdrawals. These tax forms must be filed for any year in which a MSA account withdrawal is made even if the enrollee has no taxable income or any other reason for filing Form 1040. Note that MSA account withdrawals for qualified medical expenses are tax-free, while account withdrawals for non-medical expenses are subject to both income tax and a 50% tax penalty.

- You will receive a statement (Form 1099-SA) from your MSA bank trustee reporting your MSA savings account distributions by January 31 each year. The bank trustee is also required to report this information to the IRS.
- You must file tax forms 1040 and 8853 even if you are not otherwise required to file an income tax return in order to avoid owing taxes on MSA account withdrawals.
- You must file by April 15 of the following year, unless you request an extension on your tax return.

Important reminder: Information reported to the IRS on MSA account withdrawals for qualified medical expenses is NOT the same expense information that will count towards your MSA plan deductible. Remember that only Medicare Part A and Part B expenses will count towards your MSA plan deductible. Therefore, you will also want to keep track of your qualified medical expenses that are also Part A and Part B expenses and that will count towards your MSA plan deductible.

More information on MSA tax-reporting requirements

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

There are two IRS Publications relevant to Medicare MSAs:

- IRS Publication 969, titled "Health Savings Accounts and Other Tax-Favored Health Plans", includes information on medical savings accounts, including Medicare MSAs. Publication 969 has information on what are qualified medical expenses for MSAs, which adds to medical expense information in Publication 502. (*See below for information from Publication 969 on qualified medical expenses. You generally cannot use your MSA account to pay for health insurance premiums, including drug plan premiums. You can, however, use your MSA account to purchase non-prescription drugs.)
- IRS Publication 502, titled "Medical and Dental Expenses", defines what types of services generally count as qualified medical expenses for IRS tax purposes.

These publications are available on the web at www.irs.gov or from 1-800-TAX-FORM (1-800-829-3676). On the web, look up publications by number at "Publications".

Form 1040, U.S. Individual Income Tax Return, and Form 8853 must be filed in order to avoid owing taxes on MSA account withdrawals.

- Form 8853, "Archer MSAs and Long-Term Care Insurance Contracts", Section B, is the place to report both on Medicare MSA account withdrawals (which the IRS calls distributions) and on the enrollee's qualified medical expenses for the year.

Form 8853 and Form 8853 Instructions are available at www.irs.gov or from 1-800-TAX-FORM (1-800-829-3676). On the web, look up forms by number at "Forms". (Note: IRS tax code considers Medicare MSAs a type of "Archer" MSA, therefore, IRS references to "Archer" MSAs include Medicare MSAs.)

* More details on qualified medical expenses discussed in Publication 969:

- You generally cannot use your MSA account to pay for health insurance premiums. Health insurance premiums, including drug plan premiums, are not a qualified medical expense when you pay for them with money from your MSA account (while these are included in Publication 502). Other insurance premiums, such as for long-term care, are qualified medical expenses for purposes of both Publication 969 and Publication 502.
- You can use your MSA account to purchase non-prescription drugs. Non-prescription drugs are qualified medical expenses in MSAs. (Note that insulin is the only non-prescription drug included in Publication 502).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Who to call for more information or for help in preparing your tax return

You may call the IRS toll-free for live telephone assistance from Monday – Friday, 7 a.m. – 10 p.m. local time, or you may visit your local IRS office.

- For individuals: 1-800-829-1040
- For people with hearing impairments: 1-800-829-4059 (TDD)
- Face-to-Face Assistance -- In certain areas, IRS also has local offices. Find your local office at www.irs.gov/localcontacts/index.html on the web.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

4. How to File a Grievance

[***Note to SNPs***: Revise the following language, as appropriate, to incorporate information about the process available to beneficiaries to pursue grievances related to Medicaid-covered services.]

All plan types

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an initial determination or an appeal as described in Section 5 of this manual.

Grievances do not involve problems related to approving or paying for [***Note to MA-PDs and PDPs:*** insert "Part D drugs,"] [***Note to all plan types except PDPs:*** insert "Part C medical care or services, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon].

If we will not pay for or give you the [***Note to all plan types except PDPs:*** insert "Part C medical care or services"] [***Note to MA-PDs and PDPs:*** insert "or Part D drugs"] you want, [***Note to all plan types except PDPs:*** insert "you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon,"] you must follow the rules outlined in Section 5.

What types of problems might lead to your filing a grievance?

- Problems with the service you receive from Member Services.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in Section 5.
- We don't give you a decision within the required time frame.
- We don't give you required notices.
- You believe our notices and other written materials are hard to understand.
- [***MA-PDs and PDPs*:** insert bullet] Waiting too long for prescriptions to be filled.
- [***MA-PDs and PDPs*:** insert bullet] Rude behavior by network pharmacists or other staff.
- [***MA-PDs and PDPs*:** insert bullet] We don't forward your case to the Independent Review Entity if we do not give you a decision on time.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

- [***All plan types except PDPs:*** insert bullet] Problems with the quality of the medical care or services you receive, including quality of care during a hospital stay.
- [***All plan types except PDPs:*** insert bullet] Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- [***All plan types except PDPs:*** insert bullet] Problems getting appointments when you need them, or waiting too long for them.
- [***All plan types except PDPs:*** insert bullet] Rude behavior by doctors, nurses, receptionists, or other staff.
- [***All plan types except PDPs:*** insert bullet] Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance."

Who may file a grievance

You or someone you name may file a grievance. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Member Services.

Filing a grievance with our Plan

If you have a complaint, you or your representative may call the phone number for [***Note to all plan types except PDPs:*** insert "**Part C Grievances** (for complaints about Part C medical care or services)"] [and/or] [***Note to MA-PDs and PDPs:*** insert "**Part D Grievances** (for complaints about Part D drugs)"] in Section 8. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this** [***Note to all plans:*** insert name of your grievance procedure, then insert description of the procedures (including time frames) and instructions about what members need to do if they want to use it. Be sure to

describe expedited grievance time frames for grievances about decisions to not conduct expedited organization/coverage determinations or reconsiderations/redeterminations.]

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

Fast Grievances

In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in Section 5.

For quality of care problems, you may also complain to the QIO

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 8 for more information about the QIO and for the name and phone number of the QIO in your state.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

5. Complaints and Appeals about your [Part D Prescription Drug(s) and/or Part C Medical Care and Service(s)]

Introduction

This section explains how you ask for coverage of your [***Note:*** plans insert either "Part D drug(s)" AND/OR "Part C medical care or service(s)" as applicable to your plan type] or payments in different situations. [***Note to all plan types except PDPs****:* insert "This section also explains how to make complaints when you think you are being asked to leave the hospital too soon, or you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon."] These types of requests and complaints are discussed below in Part 1[***Note to all plan types except PDPs****:* insert ", Part 2, or Part 3"].

Other complaints that do not involve the types of requests or complaints discussed below in Part 1[***Note to all plan types except PDPs****:* insert ", Part 2, or Part 3"] are considered **grievances**. You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for [Part D drugs and/or Part C medical care or services]. For more information about grievances, see Section 4.

[***Note to Cost Plans***: Cost plans may adapt the wording of this paragraph to reflect how the plan is structured.] As stated in Section 2, you may use out-of-network providers. However, if you use out-of-network providers for care that is not emergent or urgently needed care, you will usually have to pay Original Medicare cost-sharing amounts for your care. If you have a complaint about a bill when you receive care from an out-of-network provider, the appeals process in Section 5 will not apply (unless you were directed to go to that out-of-network provider by the Plan or one of the network providers). Instead, please refer to the notice of the service you receive from Original Medicare. It is called a Medicare Summary Notice (MSN). The MSN will provide information on how to appeal a decision made by Original Medicare.

[***Note: All Cost Plans except HCPPs***: add.] If you have a complaint regarding a service provided by a hospital or skilled nursing facility that is not part of the Plan network, you will follow Original Medicare rules as provided in your 2009 *Medicare & You* Handbook. However, if you

have a complaint involving a plan network hospital or skilled nursing facility (or you were directed to go to a non-plan network hospital or skilled nursing facility by the Plan or one of the network providers), you will follow the instructions contained in this section. This is true even if you received a Medicare Summary Notice (MSN) indicating that a claim was processed but not covered by Original Medicare. Furthermore, if you have a complaint regarding an emergency service or urgently needed care, or the cost-sharing for hospital or skilled nursing facility services, you will follow the instructions contained in this section. See Section 2 for guidance on what is emergency or urgently needed care.

Part 1. Requests for [Part D drugs and/or Part C medical care or services] **or payments.**

> [***Note to Cost-Plans***: insert "Please note that if you have complaints about optional supplemental benefits, you file an appeal."]
>
> [***Note to MSAs***: insert "This includes complaints about our decisions regarding whether your expenses, paid for with money from your MSA bank account or paid for out-of-pocket, constitute Medicare expenses that count towards the deductible."]

[***Note to all plan types except PDPs:*** insert "**Part 2. Complaints if you think you are asked to leave the hospital too soon**."]

[***Note to all plan types except PDPs:*** insert "**Part 3. Complaints if you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.**"]

PART 1. Requests for [Part D drugs and/or medical care or services] or payment

This part explains what you can do if you have problems getting the [Part D drugs and/or Part C medical care or service] you request, or payment (including the amount you paid) for a [Part D drug and/or Part C medical care or service] you already received.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

If you have problems getting the [Part D drugs and/or Part C medical care or services] you need, or payment for a [Part D drug and/or Part C service] you already received, you must request an initial determination with the plan.

Initial Determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a [Part D drug and/or Part C medical care or service] you need, or paying for a [Part D drug and/or [Part C] medical care or service] you already received. [***Note to MA-PDs and PDPs:*** insert: "Initial decisions about Part D drugs are called "**coverage determinations**.""] [***Note to all plan types except PDPs:*** insert: "Initial decisions about Part C medical care or services are called "**organization determinations**.""] With this decision, we explain whether we will provide the [Part D drug and/or Part C medical care or service] you are requesting, or pay for the [Part D drug and/or Part C medical care or service] you already received. [***Note to MSAs***: insert "Initial determinations also include decisions regarding whether your expenses, paid for with money from your MSA bank account or paid for out-of-pocket, constitute Medicare expenses that count towards the deductible."]

The following are examples of requests for initial determinations:

- [***MA-PDs and PDPs*:** insert bullet] You ask us to pay for a prescription drug you have received.
- [***MA-PDs and PDPs*:** insert bullet] You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." **See "What is an exception?" below for more information about the exceptions process.**
- [***MA-PDs and PDPs*:** insert bullet] You ask for an exception to our utilization management tools - such as [***Note:*** insert examples, such as prior authorization, dosage limits, quantity limits, or step therapy requirements]. Requesting an exception to a utilization management tool is a type of formulary exception. **See "What is an exception?" below for more information about the exceptions process.**
- [***MA-PDs and PDPs*:** insert bullet if applicable] You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." **See "What is an exception?" below for more information about the exceptions process.**
- [***MA-PDs and PDPs*:** insert bullet] You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the

Plan. See "Filling Prescriptions Outside of Network" in Section 2 for a description of these circumstances.

- [***All plan types except PDPs:*** insert bullet] You are not getting Part C medical care or services you want, and you believe that this care is covered by the Plan.
- [***All plan types except PDPs:*** insert bullet] We will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.
- [***All plan types except PDPs:*** insert bullet] You are being told that a medical treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- [***All plan types except PDPs:*** insert bullet] You have received Part C medical care or services that you believe should be covered by the Plan, but we have refused to pay for this care.
- [***MSAs*:** insert bullet] We make a decision regarding whether your expenses, paid for with money from your MSA Bank Account or paid for out of pocket, constitute Medicare expenses that count towards the deductible.
- [*MSAs*: insert bullet] You believe that, prior to meeting the deductible, you have been required to pay more for a service than the Medicare allowable amount.

MA-PDs and PDPs

What is an exception?

An exception is a type of initial determination (also called a "coverage determination") involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in a number of situations.

- You may ask us to cover your Part D drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan [***Note: If the plan covers excluded drugs through an enhanced plan, insert the following language*** "unless coverage is through an enhanced plan that covers those excluded drugs".
- You may ask us to waive coverage restrictions or limits on your Part D drug. For example, for certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more. See Section 2 ("Utilization Management") to learn more about our additional coverage restrictions or limits on certain drugs."
- [***Note: If the plan uses cost-sharing tiers to manage its formulary, insert the following language:*** You may ask us to provide a higher level of coverage for your Part D drug. If

your Part D drug is contained in our [non-preferred/highest tier subject to the tiering exceptions process] tier, you may ask us to cover it at the cost-sharing amount that applies to drugs in the [preferred/lowest tier subject to the tiering exceptions process] tier instead. This would lower the [coinsurance/co-payment] amount you must pay for your Part D drug. Please note, if we grant your request to cover a Part D drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.] [Note: If the Plan designated one of its tiers as a "high-cost/unique drug tier" and is exempting that tier from the exceptions process, include the following language: "Also, you may not ask us to provide a higher level of coverage for Part D drugs that are in the [tier designated as the high-cost/unique drug tier] tier."]

Generally, we will only approve your request for an exception if the alternative Part D drugs included on the Plan formulary [***Note:*** If the plan uses cost-sharing tiers to manage its formulary, insert "or the Part D drug in the preferred tier"] would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request.

If we approve your exception request, our approval is valid for the remainder of the Plan year, so long as your doctor continues to prescribe the Part D drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a Part D non-formulary drug, you cannot request an exception to the co-payment or coinsurance amount we require you to pay for the drug.

You may call us at the phone number shown under **Part D Coverage Determinations** in Section 8 to ask for any of these requests.

All plan types

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your "appointed representative." You may name a relative,

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. [***Note to all plan types except PDPs:*** insert: "If you are requesting Part C medical care or services, this statement must be sent to us at the address or fax number listed under "**Part C Organization Determinations**" in Section 8."] [***Note to MA-PDs and PDPs:*** insert "If you are requesting Part D drugs, this statement must be sent to us at the address or fax number listed under "**Part D Coverage Determinations**" in Section 8."] To learn how to name your appointed representative, you may call Member Services.

You also have the right to have a lawyer act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a “standard" or "fast" initial determination

A decision about whether we will give you, or pay for, the [Part D drug and/or Part C medical care or service] you are requesting can be a “standard" decision that is made within the standard time frame, or it can be a “fast" decision that is made more quickly. A fast decision is also called an “expedited" decision.

Asking for a standard decision

To ask for a standard decision for a [Part D drug and/or Part C medical care or service] you, your doctor, or your representative should [***Note:*** If the plan accepts standard requests by telephone, insert "call,"] fax, or write us at the numbers or address listed under [***Note to MA-PDs and PDPs:*** insert: "**Part D Coverage Determinations** (for appeals about Part D drugs)"] [***Note to all plan types except PDPs:*** insert: "**Part C Organization Determinations** (for appeals about Part C medical care or services)"] in Section 8.

[***Note***: Specify instructions for delivering requests that are made outside of regular weekday business hours if the Plan has a different process for doing so.]

Asking for a fast decision

You may ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for benefits that you have not yet received. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.)

If you are requesting a [Part D drug and/or Part C medical care or service] that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under [**Part D Coverage Determinations** (for appeals about Part D drugs) and/or **Part C Organization Determinations** (for appeals about Part C medical care or services)] in Section 8.

[***Note***: Specify instructions for delivering requests that are made outside of regular weekday business hours if the Plan has a different process for doing so.]

Be sure to ask for a "fast," or "expedited" review. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance" if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 8). If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- [***MA-PDs and PDPs*:** insert bullet] For a standard initial determination about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your request is for a Part D drug that you have not received yet and your health condition requires us to. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as [***Note:*** insert examples, such as prior authorization, dosage limits, quantity limits, or step therapy requirements], we must give you our decision no later than 72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is medically necessary.

If you have not received an answer from us within 72 hours after we receive your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- [***MA-PDs and PDPs*:** insert bullet] For a fast initial determination about a Part D drug that you have not yet received.

  If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review. We will give you the decision sooner if your health condition requires us to. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary.

  If we decide you are eligible for a fast review and you have not received an answer from us within 24 hours after receiving your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- [***All plan types except PDPs:*** insert bullet] For a decision about payment for Part C medical care or services you already received.

  If we do not need more information to make a decision, we have up to 30 days to make a decision after we receive your request, although a small number of decisions may take longer. However, if we need more information in order to make a decision, we have up to

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

60 days from the date of the receipt of your request to make a decision. You will be told in writing when we make a decision.

If you have not received an answer from us within 60 days of your request, you have the right to appeal.

- [***All plan types except PDPs:*** insert bullet] For a standard decision about Part C medical care or services you have not yet received.

  We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance". For more information about fast grievances, see Section 8.

  If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

- [***All plan types except PDPs:*** insert bullet] For a fast decision about Part C medical care or services you have not yet received.

  If you receive a "fast" decision, we will give you our decision about your requested medical care or services within 72 hours after we receive the request. However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If we take additional days, we will notify you in writing. If you believe that we should not take any extra days, you can file a fast grievance. We will call you as soon as we make the decision.

  If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a "fast grievance." For more information about fast grievances, see Section 4.

What happens if we decide completely in your favor?

- [***MA-PDs and PDPs*:** insert bullet] For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

  We must cover the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 72 hours after we receive your physician's "supporting statement." If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request (or supporting statement if your request involves an exception).

- [***MA-PDs and PDPs*:** insert bullet] For a fast decision about a Part D drug that you have not yet received.

  We must cover the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement."

- [***All plan types except PDPs:*** insert bullet] For a decision about payment for Part C medical care or services you already received.

  Generally, we must send payment no later than 30 days after we receive your request, although a small number of decisions may take up to 60 days. If we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make payment.

- [***All plan types except PDPs:*** insert bullet] For a standard decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 14 days of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

- [***All plan types except PDPs:*** insert bullet] For a fast decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 72 hours of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If an initial determination does not give you all that you requested, you have the right to appeal the decision. (See **Appeal Level 1**.)

Appeal Level 1: Appeal to the Plan

You may ask us to review our initial determination, even if only part of our decision is not what you requested. [***Note to MA-PDs and PDPs:*** insert "An appeal to the plan about a Part D drug is also called a plan "**redetermination**."""] [***Note to all plan types except PDPs****:* insert: "An appeal to the plan about Part C medical care or services is also called a plan "**reconsideration**."""] When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

[***MA-PDs and PDPs*****:** insert] If you are appealing an initial decision about a Part D drug, you or your representative may file a **standard appeal** request, or you, your representative, or your doctor may file a **fast appeal** request. Please see "Who may ask for an initial determination?" for information about appointing a representative.

[***All plan types except PDPs:*** insert] If you are appealing an initial decision about Part C medical care or services, the rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an initial determination?" However, providers who do not have a contract with the Plan may also appeal a payment decision as long as the provider signs a "waiver of payment" statement saying it will not ask you to pay for the Part C medical care or service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal about a [Part D drug and/or Part C medical care or service] a signed, written appeal request must be sent to the address listed under [**Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about medical care or services)] in Section 8.

[***Note:*** If the plan accepts oral requests for standard appeals, insert "You may also ask for a standard appeal by calling us at the phone number shown under [**Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services)] in Section 8."]

2. Asking for a fast appeal

If you are appealing a decision we made about giving you a [Part D drug and/or Part C medical care or service] that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under [**Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services)] in Section 8.

[***Note***: Specify instructions for delivering requests that are made outside of regular weekday business hours if the Plan has a different process for doing so.]

Be sure to ask for a "fast" or "expedited" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if

PRA Disclosure Statement

your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance" if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast appeal, we will give you a standard appeal.

[***Note***: If you have appeals sent to a different office than where your initial determinations are sent, you should mention that while the process for deciding on a standard or fast appeal is the same as the process at the initial determination level, the place where the appeal is sent is different; also include instructions for where to send appeal requests.]

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you or your representative. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under [**Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services)] in Section 8.

You may also deliver additional information in person to the address listed under [**Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services)] in Section 8.

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under [**Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services)] in Section 8. [*Note: If a fee is charged, insert* "We are allowed to charge a fee for copying and sending this information to you."]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

How soon must we decide on your appeal?

- [***MA-PDs and PDPs*:** insert bullet] For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug you have already paid for and received.

  We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if you have not received the drug yet and your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to Appeal Level 2.

- [***MA-PDs and PDPs*:** insert bullet] For a fast decision about a Part D drug that you have not yet received.

  We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2.

- [***All plan types except PDPs:*** insert bullet] For a decision about payment for Part C medical care or services you already received.

  After we receive your appeal request, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

- [***All plan types except PDPs:*** insert bullet] For a standard decision about Part C medical care or services you have not yet received.

  After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

- [***All plan types except PDPs:*** insert bullet] For a fast decision about Part C medical care or services you have not yet received.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- [***MA-PDs and PDPs*:** insert bullet] For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

  We must cover the Part D drug you requested as quickly as your health requires, but no later than 7 calendar days after we receive the request. If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

- [***MA-PDs and PDPs*:** insert bullet] For a fast decision about a Part D drug that you have not yet received.

  We must cover the Part D drug you requested no later than 72 hours after we receive your request.

- [***All plan types except PDPs:*** insert bullet] For a decision about payment for Part C medical care or services you already received.

  We must pay within 60 days of receiving your appeal request.

- [***All plan types except PDPs:*** insert bullet] For a standard decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 30 days of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

- [***All plan types except PDPs:*** insert bullet] For a fast decision about Part C medical care or services you have not yet received.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

We must authorize or provide your requested care within 72 hours of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity. [*Note: If a fee is charged, insert*: We are allowed to charge you a fee for copying and sending this information to you.]

How to file your appeal

[***MA-PDs and PDPs*:** insert] If you asked for Part D drugs or payment for Part D drugs and we did not rule completely in your favor at Appeal Level 1, you may file an appeal with the IRE. If you choose to appeal, you must send the appeal request to the IRE. The decision you receive from the plan (Appeal Level 1) will tell you how to file this appeal, including who can file the appeal and how soon it must be filed.

[***All plan types except PDPs*:** insert] If you asked for Part C medical care or services, or payment for Part C medical care or services, and we did not rule completely in your favor at Appeal Level 1, your appeal is automatically sent to the IRE.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the plan had at **Appeal Level 1**.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- [***MA-PDs and PDPs*:** insert bullet] For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

- [***MA-PDs and PDPs*:** insert bullet] For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.

- [***MA-PDs and PDPs*:** insert bullet] For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

- [***All plan types except PDPs:*** insert bullet] For a decision about payment for Part C medical care or services you already received.

  We must pay within 30 days after we receive notice reversing our decision.

- [***All plan types except PDPs:*** insert bullet] For a standard decision about Part C medical care or services you have not yet received.

  We must authorize your requested Part C medical care or service within 72 hours, or provide it to you within 14 days after we receive notice reversing our decision.

- [***All plan types except PDPs:*** insert bullet] For a fast decision about Part C medical care or services.

  We must authorize or provide your requested Part C medical care or services within 72 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the [Part D drug and/or Part C medical care or service] you asked for meets the minimum requirement provided in the IRE's decision. During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested [Part D drug and/or Part C medical care or service] does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC).

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level

5). The MAC will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the MAC decided not to review your appeal request.

How to file your appeal

In order to request judicial review of your case, you must file a civil action in a United States district court within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council will tell you how to request this review, including who can file the appeal.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested [Part D drug and/or Part C medical care or service] does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

PRA Disclosure Statement

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by a Federal Court Judge.

If the Judge decides against you:

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- [***MA-PDs and PDPs*:** insert bullet] For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.

- [***MA-PDs and PDPs*:** insert bullet] For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.

- [***MA-PDs and PDPs*:** insert bullet] For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

- [***All plan types except PDPs:*** insert bullet] For a decision about Part C medical care or services, we must pay for, authorize, or provide the medical care or service you have asked for within 60 days of the date we receive the decision.

[***SNP Plans*:** Add the following language: "As a plan member, some of your plan services may also be covered by Medicaid. Therefore, if you believe that we improperly denied you a service or payment for a service, you may also have the right to appeal this decision to Medicaid. We will let you know in writing if you have the right to appeal our decision to Medicaid."] [***Note***: Add Medicaid process here.]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

All plans except PDPs

PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are admitted to the hospital, you have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

Within two days of admission as an inpatient or during pre-admission, someone at the hospital must give you a notice called the Important Message from Medicare (call Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI). This notice explains:

- Your right to get all medically necessary hospital services paid for by the Plan (except for any applicable co-payments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable co-payments or deductibles).

You (or your representative) will be asked to sign the Important Message from Medicare to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end – only that you received and understand the notice.** If the hospital gives you the Important Message from Medicare more than 2 days before your discharge day, it must give you a copy of your signed Important Message from Medicare before you are scheduled to be discharged.

Review of your hospital discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

PRA Disclosure Statement

What is the "Quality Improvement Organization"?

[***Note*:** If EOC is for a single state, adapt this subsection to use the actual name of the QIO] "QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting the QIO to review your hospital discharge

You must quickly contact the QIO. The Important Message from Medicare gives the name and telephone number of the QIO and tells you what you must do.

- You must ask the QIO for a **"fast review"** of your discharge. This "fast review" is also called an "immediate review."
- You must request a review from the QIO no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the QIO.**
- The QIO will look at your medical information provided to the QIO by us and the hospital.
- During this process, you will get a notice giving our reasons why we believe that your discharge date is medically appropriate.
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if the QIO decides in your favor?

We will continue to cover your hospital stay (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

What happens if the QIO agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gave you its first decision.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

If the QIO upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section. If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

PART 3. Complaints (appeals) if you think coverage for your skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility services, is ending too soon

When you are a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

Your provider will give you written notice called the Notice of Medicare Non-Coverage at least 2 days before coverage for your services ends (call Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/). You (or your representative) will be asked to sign and date this notice to show that you received it.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.

Getting QIO review of our decision to end coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the Quality Improvement Organization (the "QIO") to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for QIO review?

You must quickly contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must contact the QIO no later than noon of the day after you get the notice.
- If you get the notice more than 2 days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

What will happen during the QIO's review?

The QIO will ask why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO. During this process, you will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for your services should end. Call Member Services or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/).

The QIO will make a decision within one full day after it receives all the information it needs.

What happens if the QIO decides in your favor?

We will continue to cover your SNF, HHA or CORF services (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

What happens if the QIO agrees that your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10

If the QIO upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal Court. If either the MAC or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you get after your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services (except for any applicable

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

PRA Disclosure Statement

6. Ending your Membership

All Plan Types

Ending your membership in our Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you *want* to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

MA and MA-PD (but not PFFS)

There are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare fall open enrollment period (also known as the "Annual Election Period"), which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get extra help, or who move, can make changes at other times. For more information on when you can make changes see the enrollment period table later in this section.

If you want to end your membership in our plan during this time, this is what you need to do:

- **If you are planning on enrolling in a new Medicare Advantage plan**: Simply join the new plan. You will be disenrolled from our plan when your new plan's coverage begins on January 1.
- **If you are planning on switching to the Original Medicare Plan and joining a Medicare Prescription drug plan:** Simply join the new Medicare Prescription drug plan. You will be disenrolled automatically from our plan when your new coverage begins on January 1.
- **If you are planning on switching to the Original Medicare Plan without a Medicare Prescription drug plan:** Contact Member Services or call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048. Your enrollment in Original Medicare will be effective January 1.

[***Note:*** MSA plans use the following instruction for ending membership]
If you want to end your membership in our plan, you must contact us to disenroll. You cannot disenroll through 1-800-MEDICARE. Contact Member Services to request disenrollment from our plan.]

PFFS plans

There are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare fall open enrollment period (also known as the "Annual Election period"), which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get extra help, or who move, can make changes at other times. For more information on when you can make changes see the enrollment period table later in this section.

If you want to end your membership in our plan during this time, this is what you need to do:

- **If you are planning on enrolling in a new Medicare Advantage plan**: Simply join the new plan. You will be disenrolled from our plan when your new plan's coverage begins on January 1.

[***Note to PFFS plans with drug coverage:*** insert bullet below]

- **If you want to switch to the Original Medicare Plan and join a Medicare prescription drug plan:** Simply join the new plan. You will be disenrolled from our plan and enrolled in Original Medicare when your new plan's coverage begins on January 1.

[***Note to PFFS plans without drug coverage****:* insert bullet below]

- **If you want to switch to Original Medicare Plan:** You must contact us or call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048. Your enrollment in Original Medicare will be effective January 1.

  If you are already enrolled in a Medicare prescription drug plan, you will continue to be enrolled in your current plan -- disenrollment from our plan will not affect your

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

enrollment. However, if you want to join a new Medicare prescription drug plan, you must request enrollment in the plan of your choice. Enrollment in the new drug plan will not automatically disenroll you from our plan. Your coverage will be effective January 1.

[Note: if plan does not offer drug coverage, use this sentence: "If you do not have Medicare prescription drug coverage with another plan, you can join another Medicare Advantage plan that does not offer drug coverage or you can switch to the Original Medicare plan."]

PDP plans

There are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare fall open enrollment period (also known as the "Annual Election Period"), which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get extra help, or who move, can make changes at other times. For more information on when you can make changes see the enrollment period table at the end of this section.

During the fall open enrollment period, if you want to end your membership in our plan, this is what you need to do:

- **If you are planning on joining another Medicare Prescription drug plan:** Simply join the new Medicare Prescription drug plan. You will be disenrolled automatically from our plan when your new coverage begins on January 1.

- **If you are planning on enrolling in a Medicare Advantage plan**: Request enrollment in the new plan. In most cases, you will be disenrolled automatically when your new plan's coverage begins on January 1.

  EXCEPTION -- If you are joining a Medicare Advantage "Private Fee-for-Service" plan and that plan does not offer drug coverage, or a Medicare Medical Savings Account (MSA) Plan, enrollment will not automatically disenroll you from our plan. Therefore, you will need to do the following:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

- To join a new Medicare prescription drug plan, simply join the new Medicare prescription drug plan, or
- If you do not want Medicare prescription drug coverage, request disenrollment from our plan by contacting us or calling 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048.

- **If you would like to end your membership without joining any other Medicare health or prescription drug plan:** Contact us or call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048. Your enrollment in Original Medicare will be effective January 1.

IMPORTANT -- If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage (coverage that is at least as good as Medicare drug coverage), you may have to pay a penalty if you join later.

Cost Plans

Voluntarily ending your membership

You may end your membership in our Plan at any time during the year and go to the Original Medicare Plan. Your membership will end on the first of the month following your request to our Plan. To end your membership, you must make this request in writing to us. Contact us if you need more information on how to do this. [***Note to Cost plans with drug coverage:*** insert "If you have drug coverage through our plan and you leave our plan during the year, you will have the opportunity to join another Medicare prescription drug plan when you leave."]

If you want to end your membership and join another Medicare health plan or prescription drug coverage, there are limited times when you may join such plans. The Medicare fall open enrollment period (also known as the "Annual Election Period") occurs every year from November 15 through December 31. This is the key time to review your health care and drug coverage and change your Medicare health or prescription drug coverage for the following year. Any changes you make during this time will be effective January 1.

All plans except Dual SNPs insert chart below

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Enrollment Period	When?	Effective Date
Fall Open Enrollment (Annual Election Period) Time to review health and drug coverage and make changes.	Every year from November 15 to December 31	January 1
Medicare Advantage (MA) Open Enrollment [***MSA plans:*** delete this row discussing the MA-OEP] Cannot use this period to [***MA-PDs insert*** "drop"/***MA-only plans insert*** "add"/PFFS plans insert "add or drop"] Medicare prescription drug coverage Examples: If you are in a MA plan that does not have Medicare prescription drug coverage, you can switch to another Medicare Advantage plan that does not offer drug coverage or go to Original Medicare If you are in Original Medicare Plan and have a Medicare prescription drug plan, you can join a Medicare Advantage Plan that offers Medicare drug coverage If you are in an MA plan that	Every year from January 1 to March 31	First day of next month after plan receives your enrollment request

offers Medicare drug coverage, you can leave and join Original Medicare Plan and a Medicare prescription drug plan		
Special Enrollment Periods for limited special exceptions, such as: • You have a change in residence • You have Medicaid • You are eligible for extra help with Medicare prescriptions • You live in an institution (such as a nursing home)	Determined by exception.	Generally, first day of next month after plan receives your enrollment request

For more information about the options available to you during these enrollment periods, contact Medicare at 1-800-MEDICARE (1-800-633-4227.) TTY users should call 1-877-486-2048. Additional information can also be found in the *"Medicare & You"* handbook. This handbook is mailed to everyone with Medicare each fall. You may view or download a copy from www.medicare.gov - under "Search Tools," select "Find a Medicare Publication."

Until your membership ends, you must keep getting your Medicare [services and/or prescription drug coverage] through our Plan

All plan types

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). While you are waiting for your membership to end, you are still a member and must continue to get your [care and/or prescription drugs] as usual through our Plan. [***All plans except PDPs:*** insert: "If you happen to be hospitalized on the day your membership ends, generally you will be

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

covered by our Plan until you are discharged. Call Member Services for more information and to help us coordinate with your new plan.]

Cost Plans

If you see out-of-network providers to obtain medical services, the services are covered under Original Medicare. You will be responsible for the Original Medicare cost-sharing for such services, with the exception of emergent and urgently needed services. [***Note if offer Part D:*** insert "If you get prescription drugs from an out-of-network provider, you will be responsible for the cost of the drug."]

MA-PDs and PDPs

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy [or through our mail-order-pharmacy service], are listed on our formulary, and you follow other coverage rules.

MSA Plans

What happens to the money in your account if you leave our Plan?

If you leave our Plan in the middle of the year, part of the most recent deposit (based on the number of months left in the current calendar year) will have to be refunded to Medicare. If you are disenrolled from a Medicare Saving Account Plan mid-year, the amount deposited into your account for the remaining months in the year will be recovered from you and returned to Medicare after your disenrollment is confirmed. Funds remaining in your account from the previous year belong to you. Recovery applies only to funds deposited into your account for the current year. Example: If you get a $1,200 deposit in your account in January and disenroll in March, we will recover $900 to return to Medicare. If you have any questions about this, please contact Member Services.

All Plan Types except MA chronic Care SNPs

We cannot ask you to leave the Plan because of your health.

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

All Plan Types (plans should modify as appropriate to plan options)

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan.

- If you do not stay continuously enrolled in [MA use "Medicare A and B"; PDP use "Medicare A or B (or both) [***Note to Cost plans and plans with Part B -only grandfathered members*:** mention that these members need to stay continuously enrolled in Medicare Part B].
- [***Note to SNPs***: include] If you no longer are [insert SNP category].
- [***Note to MSAs:*** include] If you no longer meet the additional MSA eligibility requirements, with the exception of hospice care and end-stage renal disease, as outlined in Section 1.
- If you move out of the service area or are away from the service area for more than [***Note to PDP and MA without visitor/traveler:*** insert "6 months"; ***MA with visitor/traveler insert*** "[# up to 12] months"/***Cost plans insert*** "[# between 90 days and up to 12 months]" you cannot remain a member of our Plan. And we must end your membership ("disenroll" you)". If you plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our Plan's service area. [***Note to plans with visitor/traveler benefits***: insert "Section 10 gives more information about getting care when you are away from the service area."] [***Note to MA plans with grandfathered members who were outside of area prior to January 1999:*** insert "If you have been a member of our plan continuously since before January 1999, when you lived outside our service area, you may continue your membership. However, if you move and your move is still outside our service area, will be disenrolled from our Plan, as stated above."]
- [***Note to MA-PD, PDP, and Cost Plans with Part D***: include] If you knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage.
- [***Note:*** delete bullet if not applicable] If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.
- [***Note:*** delete bullet if not applicable] If you behave in a way that is [***Note to Cost plans:*** insert "unruly, uncooperative, abusive, or"] disruptive, to the extent that you

continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.

- [***Note:*** delete bullet if not applicable] If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- [***Note***: this bullet for all plans except Cost plans - delete bullet if not applicable] If you do not pay the Plan premiums, we will tell you in writing that you have a [insert time frame] grace period during which you may pay the Plan premiums before your membership ends.
- [***Note:*** this bullet for Cost plans only – delete bullet if not applicable] If you do not pay the basic plan premiums or cost-sharing, we will tell you in writing before you are required to leave our Plan.

All Plan Types

You have the right to make a complaint if we end your membership in our Plan

If we end your membership in our Plan we will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

7. Definitions of Important Words Used in the EOC

[***Note to all plans:*** Insert definitions as appropriate to the plan type described in the EOC. You may insert definitions not included in this model and exclude model definitions not applicable to your plan, or to your contractual obligations with CMS or enrolled Medicare beneficiaries.]

[***Note to all plan types except PDPs***: If you use any of the following terms in your EOC, you must add a definition of the term to the first section where you use it and here in Section 7 with a reference from the section where you use it: IPA, network, PHO, plan medical group, Point of Service [If the plan offers a POS option, also provide definitions of: allowed amount, balance billing, coinsurance and maximum charge], and prescription drug benefit manager.]

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for [health care services and/or prescription drugs] or payment for [services and/or prescription drugs] you already received. [***Note to all plans except PDPs:*** insert "You may also make a complaint if you disagree with a decision to stop services that you are receiving."] For example, you may ask for an appeal if our Plan doesn't pay for a [drug/item/service] you think you should be able to receive. Section 5 explains appeals, including the process involved in making an appeal.

Benefit period – For [both our Plan and] the Original Medicare Plan, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. [***Note:*** If you offer a more generous benefit period, revise the following sentences to reflect the Plan's benefit period] A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage - The phase in the Part D Drug Benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent [Insert TrOOP amount] in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 8 explains how to contact CMS.

Cost-sharing - Cost-sharing refers to amounts that a member has to pay when [drugs/services] are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before [drugs/services] are covered; (2) any fixed "co-payment" amounts that a plan may require be paid when specific [drugs/services] are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a [drug/service].

Coverage Determination –A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the Plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our Plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Covered services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our Plan.

Creditable Prescription Drug Coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare's prescription drug coverage.

Custodial care -- Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Deductible -- The amount you must pay for the [health care services or drugs] you receive before our Plan begins to pay its share of your covered [services or drugs].

Disenroll or **Disenrollment** – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 6 discusses disenrollment.

Durable medical equipment – Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment are wheelchairs, hospital beds, and equipment that supplies a person with oxygen.

Emergency care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form [and any other attachments, riders, or other optional coverage selected], which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

sponsor requires you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered drugs provided by the Plan.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Grievance - A type of complaint you make about us or one of our network [providers/pharmacies], including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 4 for more information about grievances.

Home health aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care -- Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 10 under the heading "Home health care." If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice care -- A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227. TTY users should call 1-877-486-2048)

Inpatient Care – Health care that you get when you are admitted to a hospital.

Initial Coverage Limit – The maximum limit of coverage under the initial coverage period.

Initial Coverage Period – This is the period [after you have met your deductible and] before your total drug expenses, have reached $[insert 2009 initial coverage limit amount], including amounts you've paid and what our Plan has paid on your behalf.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

Medically necessary – Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

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

Medicare Advantage (MA) Plan– Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

[***Note*:** Insert Cost plan definition only if you are a Medicare Cost plan or there is one in your service area.] **Medicare Cost Plan** – Cost plan means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare supplement insurance) policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. (A Medicare Advantage plan is not a Medigap policy.)

Member (member of our Plan, or "plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 8 for information about how to contact Member Services.

Network pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they [have an agreement with our Plan to] accept our payment as payment in full, and in some cases

PRA Disclosure Statement

to coordinate as well as provide covered services to members of our Plan. Our Plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

[***Note***: Include this definition only if plan has preferred and non-preferred pharmacies] [Note: insert either "**Non-preferred network pharmacy**" or "**Other network pharmacy**"]– A network pharmacy that offers covered drugs to members of our Plan at higher cost-sharing levels than apply at a preferred network pharmacy.

[***Include if applicable:*** **Optional supplemental benefits** – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them.]

Organization Determination - The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare Plan – ("Traditional Medicare" or "Fee-for-service" Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network provider or out-of-network facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this EOC in Section 2.

Out-of-network pharmacy – A pharmacy that doesn't have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of

PRA Disclosure Statement

Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Part C – see "Medicare Advantage (MA) Plan"

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that Congress permitted our Plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs, such as benzodiazepines, barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (see Section 10 for a listing of these drugs). These drugs are not considered Part D drugs.

[***Note***: Include this definition only if plan has preferred and non-preferred pharmacies]
Preferred Network Pharmacy – A network pharmacy that offers covered drugs to members of our Plan at lower cost-sharing levels than apply at a non-preferred network pharmacy.

Primary Care [Physician] (PCP) – A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about PCPs.

Preferred Provider Organization Plan – A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing may be higher when plan benefits are received from out-of-network providers.

Prior authorization – Approval in advance to get [services AND/OR certain drugs that may or may not be on our formulary]. [***Note to plans:*** include example as appropriate to your plan type: "In an [HMO with a referral model and in the network portion of a PPO], some in-network services are covered only if your doctor or other network provider gets "prior authorization" from our Plan. Covered services that need prior authorization are marked in the Benefits Chart in Section 10." AND/OR "In a [PPO or PFFS] plan you do not need prior authorization to obtain

out-of-network services. However, you may want to check with your plan before obtaining services out-of-network to confirm that the service is covered by your plan and what your cost share responsibility is. Covered services that need prior authorization are marked in the Benefits Chart in Section 10." AND/OR "Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary."]

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 8 for information about how to contact the QIO in your state and Section 5 for information about making complaints to the QIO.

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

Quantity Limits - A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service area – Section 1 tells about our Plan's service area. "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan.

Skilled nursing facility (SNF) care - A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Step Therapy - A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care – Section 2 explains about "urgently needed" services. These are different from emergency services.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

8. Helpful Phone Numbers and Resources

All Plan Types

Contact Information for our Plan Member Services

If you have any questions or concerns, please call or write to our Plan Member Services. We will be happy to help you.

CALL [Insert phone number][***Add if applicable:*** "Calls to this number are free.] [Insert hours of operation, including information on use of alternative technologies.]

[***Note to dual eligible SNPs:*** as appropriate, add additional phone numbers that members may use to access specific services covered under the Medicaid program.]

TTY [Insert TTY number] This number requires special telephone equipment. [***Add if applicable:*** "Calls to this number are free."]

[FAX] [Insert fax number.]

WRITE [Insert address. You may also include e-mail addresses here]

[VISIT] [Insert street address]

WEBSITE [insert URL]

How to contact [MSA Bank] Member Services

CALL [Insert number]. [***Add if applicable:*** "Calls to this number are free."] [You may also include reference to 24-hour lines here]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

TTY [Insert number] This number requires special telephone equipment [*Add if applicable:* "Calls to this number are free."]

Contact Information for Grievances, [Organizations Determinations, Coverage Determinations] and Appeals

[***Note:*** If your plan uses the same contact information for Part C and Part D issues indicated below, you may combine these contact information sections.]

[***Note to PDPs:*** Omit Part C contact information.]

Part C Organization Determinations (about your Medicare Care and Services)

CALL [Insert phone number]. [**Add if applicable:** Calls to this number are free.] [You may also include reference to 24-hour lines here.] [If you have a different phone number for accepting expedited organization determinations, also include that number here.]

TTY [Insert TTY number]. This number requires special telephone equipment. [***Add if applicable*:** Calls to this number are free.] [If you have a different TTY number for accepting expedited organization determinations, also include that number here.]

[FAX] [***Optional:*** Insert fax number.] [If you have a different fax number for accepting expedited organization determinations, also include that number here.]

WRITE [Insert address.] [If you have a different address for accepting expedited organization determinations, also include that address here.]

For information about Part C organization determinations, see Section 5.

Part C Grievances (about your Medical Care and Services)

CALL [Insert phone number]. [***Add if applicable*:** Calls to this number are free.] [You may also include reference to 24-hour lines here.] [If you have a different phone number for accepting expedited grievances, also include that number here.]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

TTY [Insert TTY number]. This number requires special telephone equipment. [***Add if applicable*:** Calls to this number are free.] [If you have a different TTY number for accepting expedited grievances, also include that number here.]

[FAX] [***Optional:*** Insert fax number.] [If you have a different fax number for accepting expedited grievances, also include that number here.]

WRITE [Insert address.] [If you have a different address for accepting expedited grievances, also include that address here.]

For information about Part C grievances, see Section 4.

Part C Appeals (about your Medical Care and Services)

CALL [Insert phone number]. [***Add if applicable*:** Calls to this number are free.] [You may also include reference to 24-hour lines here.] [If you have a different phone number for accepting expedited appeals, also include that number here.]

TTY [Insert TTY number]. This number requires special telephone equipment. [***Add if applicable*:** Calls to this number are free.] [If you have a different TTY number for accepting expedited appeals, also include that number here.]

[FAX] [***Optional:*** Insert fax number.] [If you have a different fax number for accepting expedited appeals, also include that number here.]

WRITE [Insert address.] [If you have a different address for accepting expedited appeals, also include that address here.]

For information about Part C appeals, see Section 5.

[***Note to MA-only plans:*** Omit Part D contact information.]
Part D Coverage Determinations (about your Part D Prescription Drugs)

CALL [Insert phone number]. [***Add if applicable*:** Calls to this number are free.] [You may also include reference to 24-hour lines here.] [If you have a different phone

number for accepting expedited coverage determinations, also include that number here.]

TTY [Insert TTY number]. This number requires special telephone equipment. [***Add if applicable*:** Calls to this number are free.] [If you have a different TTY number for accepting expedited coverage determinations, also include that number here.]

[FAX] [***Optional:*** Insert fax number.] [If you have a different fax number for accepting expedited coverage determinations, also include that number here.]

WRITE [Insert address.] [If you have a different address for accepting expedited coverage determinations, also include that address here.]

For information about Part D coverage determinations, see Section 5.

[Part D Reimbursement Requests (about your Part D prescription drugs)]
[***Note:*** this section only needs added if plan does not process enrollee-submitted reimbursement requests in the same location that it processes all other coverage determination requests.]

CALL [Insert phone number]. [***Add if applicable*:** Calls to this number are free.]

TTY [Insert TTY number]. This number requires special telephone equipment. [***Add if applicable*:** Calls to this number are free.]

[FAX] [***Optional:*** Insert fax number.]

WRITE [Insert address.]

Part D Grievances (about your Part D Prescription Drugs)

CALL [Insert phone number]. [***Add if applicable*:** Calls to this number are free.] [You may also include reference to 24-hour lines here.] [If you have a different phone number for accepting expedited grievances, also include that number here.]

PRA Disclosure Statement

TTY [Insert TTY number]. This number requires special telephone equipment. [***Add if applicable*:** Calls to this number are free.] [If you have a different TTY number for accepting expedited grievances, also include that number here.]

[FAX] [***Optional:*** Insert fax number.] [If you have a different fax number for accepting expedited grievances, also include that number here.]

WRITE [Insert address.] [If you have a different address for accepting expedited grievances, also include that address here.]

For information about Part D grievances, see Section 4.

Part D Appeals (about your Part D Prescription Drugs)

CALL [Insert phone number]. [***Add if applicable*:** Calls to this number are free.] [You may also include reference to 24-hour lines here.] [If you have a different phone number for accepting expedited appeals, also include that number here.]

TTY [Insert TTY number]. This number requires special telephone equipment. [***Add if applicable*:** Calls to this number are free.] [If you have a different TTY number for accepting expedited appeals, also include that number here.]

[FAX] [***Optional:*** Insert fax number.] [If you have a different fax number for accepting expedited appeals, also include that number here.]

WRITE [Insert address.] [If you have a different address for accepting expedited appeals, also include that address here.]

For information about Part D appeals, see Section 5.

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your *Medicare & You* Handbook, visit www.medicare.gov and choose "Find Helpful Phone

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Numbers and Resources," or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

[***Note to organizations offering plans in multiple states:*** use generic organization name (SHIP, QIO, etc) when necessary, and include a list of names and phone numbers for all organizations in your service area. National plans have the option of including a separate exhibit to list the organizations in all states (example: a national chart of all QIOs by state) and should make reference to that exhibit below.]

[State-specific name of State Health Insurance Assistance Program (SHIP)]

[State-specific name of SHIP or SHIPs] is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. [State-specific name of SHIP or your SHIP] can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. [State-specific name of SHIP or your SHIP] has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, [Note: include only if offered in your plan area: "Medicare Cost Plans"], and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact [state-specific name of SHIP or the SHIP in your state] at [Insert name, address, and telephone number for all applicable SHIPS]. You may also find the website for [state-specific name of SHIP or your local SHIP] at www.medicare.gov under "Search Tools" by selecting "Helpful Phone Numbers and Websites."

[State-specific name of QIO or Quality Improvement Organization]

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital,

PRA Disclosure Statement

skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Section 5 for more information about complaints, appeals and grievances.

You may contact [name of QIO] at [name, address, and number for all applicable QIOs].

How to contact the Medicare program

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 (generally those with permanent kidney failure who need dialysis or a kidney transplant). Our organization contracts with the federal government.

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov for information. This is the official government website for Medicare**.** This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer.

Medicaid

[***Note:*** You may adapt this generic discussion of Medicaid to reflect the name and features of the Medicaid program in your state or states.]

[***Note****:* SNPs may describe the Medicaid managed care program under which the organization contracts with the state Medicaid agency.]

[***Note:*** SNPs must, as appropriate, include additional telephone numbers for Medicaid program assistance, e.g., the telephone number for the state Ombudsman.]

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

qualify. To find out more about Medicaid and its programs, contact [***Note:*** Insert name, address, and telephone number for all applicable state Medicaid agencies/state departments of health and social services. You may also add your [member services] contact information.]

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit **www.ssa.gov** on the Web.

[***Note***: If you have an SPAP in your service area, insert the following paragraph.]

[State-specific name of State Pharmacy Assistance Program (SPAP)]

[State-specific name of SPAP or SPAPs] are state organizations that provide limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. You may contact [state-specific name of SPAP or the SPAP in your state] at [Insert name, address, and telephone number for all applicable SPAPs]. The website for [state-specific name of SPAP or your local SPAP] is [website].

[***Note:*** SNPs may, as appropriate, include additional telephone numbers for Medicaid program assistance, e.g., the telephone number for the state Ombudsman.]

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or "Group") Coverage

[***Note:*** SNPs may, as appropriate, delete this language since beneficiaries covered under employer groups are not eligible to participate in dual eligible SNPs in some states.]

If you get, or your spouse gets, benefits from your current or former employer or union, or from your spouse's current or former employer or union, call the employer/union benefits administrator or Member Services if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (or your spouse's) employer/union benefits may change, or you (or your spouse) may lose the benefits, if you enroll

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

in Medicare Part D. Call your employer/union benefits administrator or Member Services to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

9. Legal Notices

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide [Medicare Advantage Plans or Medicare Prescription Drug Plans], like our Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

[***Note:*** You may include other legal notices, such as a notice of member non-liability or a notice about third party liability. These notices may only be added if they conform to Medicare laws and regulations.]

PRA Disclosure Statement

10. How Much You Pay for Your [Part C Medical Benefits and/or Part D Prescription Drugs]

[***Note*:** The requirement to include a list of covered benefits applies to all plan types.] [***Note to SNPs*:** SNP plans may add a discussion to this section if they cover benefits under Medicaid. This may include adding new language to the benefit chart itself as well as language to the related text in this section. This may be done in an additional column or additional rows or within the existing cells of the chart or grouped together at the end and labeled Medicaid benefits.]

PFFS plans

Our Plan is a Medicare Advantage Private-Fee-for-Service plan. A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at: [insert link to PFFS terms and conditions].

All plan types

Your Monthly Premium for Our Plan

[***Note:*** Plans that don't have a monthly premium can delete this section.]

Your monthly premium for our Plan is [$__] OR [The table below shows the monthly plan premium amount for each region we serve.] [***Note:*** Insert a list of or table with the state/region and monthly plan premium amount for each area included within the EOC.]

[If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits. If you have any questions about your Plan premiums or the payment programs, please call Member Services.]

[***Note:*** Plans may describe other billing options other than monthly billing.]

If you get your benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about your Plan premium.

[***MA-PDs and PDPs include:*** **"**If you are getting extra help with paying for your drug coverage, the Part D premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs." You can also get that information by calling Member Services. If you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your monthly plan premiums. Please contact your SPAP to determine what benefits are available to you. Note that there is not an SPAP in every state, and in some states the SPAP has another name. See Section 8.]

You can find more information about paying your plan premium in Section 1.

All Plan Types except PDPs

How Much You Pay for Part C Medical Benefits

This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. These are the benefits and coverage you get as a member of our Plan. Later in this section under "General Exclusions" you can find information about services that are not covered. [***Add if applicable:*** It also tells about limitations on certain services.] [***MA-PDs insert:*** "Information about how much you pay for your Part D Prescription Drug Benefits is later in this section."] [***Note***: If applicable, you may mention other places where benefits, limitations, and exclusions are described, such as optional additional benefits, or addenda.]

All Plan Types except PDPs – include if applicable

What do you pay for covered services?

[***Note:*** include reference to all applicable cost-sharing types your plan uses]

["Deductibles,"] ["co-payments,"] [and] ["coinsurance"] are the amounts you pay for covered services.

- [***Note***: Include if applicable] The **"deductible"** is the amount you must pay for the

health care services you receive before our Plan begins to pay its share of your covered services. [***Insert if applicable:*** "(Not all plans described in this EOC have a deductible. Check the benefits chart for more information on each plan.)"]

- [***Note***: Include if applicable] A **"co-payment"** is a payment you make for your share of the cost of certain covered services] you get. A co-payment is a set amount per service. You pay it when you get the service.
- [***Note***: Include if applicable] **"Coinsurance"** is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a percentage of the cost of the service. You pay your coinsurance when you get the service. [Plans may insert language explaining how coinsurance dollar amounts are determined (i.e. based on the Original Medicare Plan payment amount, etc) and indicate in benefits chart when appropriate.]
- [***MA and MA-PD plans add if applicable***: "Depending on your Medicaid benefit, you may not have to pay out-of-pocket costs for premiums, [***Note to MA-only plans with no Part C premium:*** delete "premiums,"] [deductibles,] [co-payments] [and] [coinsurances]. These costs may be covered by Medicaid, as long as you qualify for Medicaid benefits and the provider accepts Medicaid. The only exception is that you are responsible for your covered health care services [*Note*: Plan insert either: "coinsurance" OR "co-payments" OR "coinsurance or co-payments" and] your Medicaid co-payments, if applicable.]

[***Note to MA plans with no OOP max for covered medical services:*** delete next section.]

What is the maximum amount you will pay for [***Add if applicable:*** "certain"] covered medical services?

There is a limit to how much you have to pay out-of-pocket for [***Add if applicable:*** "certain"] covered health care services each year. [***Note to Plans with out-of-pocket limit:*** describe what services the OOP max applies to, including dollar amounts]

[***Note to MSA plans:*** plans must disclose their deductible amounts and any out-of-pocket maximums if applicable. If there is any cost-sharing between the deductible and the out-of-pocket maximum (demonstration plans only), that must also be disclosed. If there is a network, any differential cost-sharing must be disclosed.]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

[***Note to Regional PPOs***: Regional PPO Plans must disclose their in-network and total (inclusive of in and out of network) catastrophic cap on member cost-sharing for A and B services (see § 422.101(d)(2) and (d)(3).]

All plan types except PDPs

Benefits Chart

The benefits chart on the following pages lists the services our Plan covers and what you pay for each service. [***Insert if applicable:*** "The benefits chart lists information for more than one of our Plans. The name of the plan you are in is listed on the front page of this packet. If you aren't sure which plan you are in or if you have any questions, call Member Services."] The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- [***HMO and PPO plans that use prior authorizations insert bullet***] Some of the covered services listed in the Benefits Chart are covered only if your doctor or other network provider gets "prior authorization" (approval in advance) from our Plan. Covered services that need prior authorization are marked in the Benefits Chart by [an asterisk/footnote, in bold, in italics, etc.][***PPO plans with prior authorization requirements to access preferred network providers, insert*** "Prior authorization is only required for services obtained from a network provider. You never need prior authorization for out-of-network services from out-of-network providers." [***Insert if applicable:*** "However, our Plan will reduce your cost-sharing if you notify us before receiving out-of-network services."]]
- [***Note to PFFS***: adapt the following language for the PFFS plan that has established prior notification requirements: "Our Plan has prior notification requirements when you receive certain health care services from a provider."][***Note:*** Plan should describe what health care services have prior notification requirements and whether or not the Plan has established any higher cost-sharing requirement if the member or provider does not notify the Plan before the service is furnished. Refer to the 2009 Call Letter for more information on prior notification requirements. Insert the following sentence if the plan

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

includes such differential cost-sharing: "Note that the amount of cost-sharing you pay if you do not prior notify our Plan may be more than the cost-sharing you pay when you prior notify."]

See Section 2 for information on requirements for using network providers.

[***Instructions to All Plan Types except PDPs on completing benefits chart:***

- When preparing this Benefits Chart, please refer to any instructions contained in the cover memorandum for this standardized EOC.
- All plans with networks should clearly indicate for each service applicable the difference in cost-sharing at network and out-of-network providers and facilities.
- Plans with a POS benefit may include POS information within the benefit chart, or may include a section following the chart listing POS-eligible benefits and cost-sharing.
- Plans should clearly indicate which benefits are subject to prior authorization (plans may use asterisks or similar method).
- Plans may insert any additional benefits information based on the plan's approved bid that is not captured in the benefits chart or in the exclusions section.
- [SNPs may modify the language, as applicable, to address billing and cost-sharing for its dual eligible population.]]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
Inpatient Services	
Inpatient hospital care [List days covered and any restrictions that apply.] Covered services include: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. [***Note to network plans:*** insert "If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a	[List co-payments/coinsurance. If cost-sharing is based on benefit period, include definition/ explanation of BID approved benefit period here. Also, plans that use a per-admission deductible, include the following sentence: "A per admission deductible is applied once during a benefit period."] [***Non-network PFFS and non-network MSA plans can disregard the next paragraph.]*** If you get [authorized] inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the [***Insert if applicable:*** highest] cost-sharing you would pay at a plan hospital. [***Note to Cost plans:*** insert instead of last sentence "If you get [authorized] inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a plan hospital."]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
companion.] • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used. [Modify as necessary if the Plan begins coverage with an earlier pint.] • Physician Services	
Inpatient mental health care Covered services include mental health care services that require a hospital stay. [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 Mental Health services provided in a psychiatric unit of a general hospital.]	[List co-pays / coinsurance. If cost-sharing is based on benefit period, include definition/explanation of BID approved benefit period here.]
Skilled nursing facility (SNF) care [List days covered and any restrictions that apply, including whether any prior hospital stay is required.] Covered services include: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors)	[List co-pays/ coinsurance. If cost-sharing is based on benefit period, include definition/explanation of BID approved benefit period here.]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services

What you must pay when you get these covered services

- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used. [Modify as necessary if the Plan begins coverage with an earlier pint.]
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician services

[***Note to HMO and PPO plans***: insert "Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our Plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

Inpatient services covered when the hospital

[List co-pays / coinsurance]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
or SNF days aren't, or are no longer, covered Covered services include: • Physician services • Tests (like X-ray or lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and Orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
Home health agency care Covered services include: • 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 less than eight hours per day and 35 or fewer hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical social services • Medical equipment and supplies	[List co-pays / coinsurance]
Hospice care You may receive care from any Medicare-certified hospice program. The Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by the Original Medicare Plan • Home care [***Insert if applicable, edit as appropriate:*** "Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit."]	When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by the Original Medicare Plan, not your Medicare Advantage plan. [***Note***: Include information about cost-sharing for hospice consultation services if applicable.]

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient Services	
Physician services, including doctor office visits Covered services include: • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center • Consultation, diagnosis, and treatment by a specialist • Hearing and balance exams, if your doctor orders it to see if you need medical treatment. • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion [Insert in appropriate: by another network provider] prior to surgery • Outpatient hospital services • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor) [Also list any additional benefits offered]	[List co-pays / coinsurance]
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation [Also list any additional benefits offered]	[List co-pays / coinsurance]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
Podiatry services Covered services include: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. [Also list any additional benefits offered]	[List co-pays / coinsurance]
Outpatient mental health care (including Partial Hospitalization Services) Covered services include: • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	[List co-pays / coinsurance]
Outpatient substance abuse services	[List co-pays / coinsurance]
Outpatient surgery (including services provided at ambulatory surgical centers) Covered services include:	[List co-pays / coinsurance]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
Ambulance services Covered services include ambulance services to free standing Renal Dialysis facilities when medically necessary, to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.	[List co-pays / coinsurance. Specify whether cost-sharing applies one-way or for round trips.]
Emergency care [Identify whether this coverage is limited to the U.S. or is also available world-wide.]	[List co-pays / coinsurance. Explain (if appropriate) that cost-sharing is waived if member admitted to hospital.] [***Non-network PFFS and non-network MSA plans can disregard the next paragraph.***] If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, [***Insert either*** "you must return to a plan contracting hospital in order for your care to continue to be covered." OR "your cost is the [***Insert if applicable:*** highest] cost-sharing you would pay at a plan hospital." OR ***Cost plans insert*** "If you get inpatient care at a non-plan hospital after an emergency admission, your cost is the cost-sharing you would pay at a plan hospital."]

PRA Disclosure Statement

Benefits chart – your covered services	**What you must pay** when you get these covered services
Urgently needed care [Include in-network benefits. Also identify whether this coverage is within the U.S. or world-wide.]	[List co-pays / coinsurance. Plans should include different co-payments for Contracted Urgent Care centers, if applicable.]
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy	[List co-pays / coinsurance]
Durable medical equipment and related supplies Covered items include: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 7.)	[List co-pays / coinsurance]
Prosthetic devices and related supplies – (other than dental) that replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	[List co-pays / coinsurance]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
Diabetes self-monitoring, training and supplies – for all people who have diabetes (insulin and non-insulin users). Covered services include: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Self-management training is covered under certain conditions • For persons at risk of diabetes: Fasting plasma glucose tests. [Insert frequency] [Also list any additional benefits offered]	[List co-pays / coinsurance]
Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	[List co-pays / coinsurance]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include: • X-rays • Radiation therapy [***Note***: list separately any services for which a separate co-pay/coinsurance applies over and above the outpatient radiation therapy co-pay/coinsurance.] • Surgical supplies, such as dressings • Supplies, such as splints and casts • Laboratory tests • Blood - Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. [Modify as necessary if the Plan begins coverage with an earlier pint]. Coverage of storage and administration begins with the first pint of blood that you need. • Other outpatient diagnostic tests [Plans can include other covered tests as appropriate]	[List co-pays / coinsurance]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
Vision care Covered services include: • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year • [Adapt this description if the Plan offers more than is covered by the Original Medicare Plan] One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. [Also list any additional benefits offered, such as routine vision exams or glasses, either here or in "Vision Care" section later in benefits chart.]	[List co-pays / coinsurance]
Preventive Care and Screening Tests	
[***Note: for all preventive care and screening test benefit information*** - plans that cover a richer benefit than the Original Medicare Plan do not need to include given description (unless still applicable) and may instead describe plan benefit.]	[List co-pays / coinsurance.]
Abdominal Aortic Aneurysm Screening A one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam. [Also list any additional benefits offered.]	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
Bone-mass measurements For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. [Also list any additional benefits offered.]	[List co-pays / coinsurance.]
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy [Also list any additional benefits offered.]	[List co-pays / coinsurance]

PRA Disclosure Statement

Benefits chart – your covered services	**What you must pay** when you get these covered services
Immunizations Covered services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk [***Note to Plans offered Part D:*** include "We also cover some vaccines under our outpatient prescription drug benefit**.***"*] [***Note:*** Also list any additional benefits offered.]	[List co-pays / coinsurance]
Mammography screening Covered services include: • One baseline exam between the ages of 35 and 39 • One screening every 12 months for women age 40 and older [Also list any additional benefits offered.]	[List co-pays / coinsurance]
Pap tests, pelvic exams, and clinical breast exam Covered services include: • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months [Also list any additional benefits offered.]	[List co-pays / coinsurance]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test [Also list any additional benefits offered.]	[List co-pays / coinsurance]
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). [Insert frequency.]	[List co-pays / coinsurance]
Physical exams [***Note to any Plan that covers only what the Original Medicare covers:*** include "A one-time physical exam for members within the first 6 months that they have Medicare Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Doesn't include lab tests."]	[List co-pays / coinsurance]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services	**What you must pay** when you get these covered services
Other Services	
Dialysis (Kidney) Covered services include: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Section 2) • Inpatient dialysis treatments (if you are admitted to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	[List co-pays / coinsurance]
Medicare Part B Prescription Drugs These drugs are covered under Part B of the Original Medicare Plan. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant	[List co-pays / coinsurance]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Benefits chart – your covered services

What you must pay when you get these covered services

- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin Alfa, and Darboetin Alfa (Aranesp®)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

[***MA-PD plans insert:***
Section 2 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed later in this section.]

Additional Benefits

[***Note:*** Include if applicable] Dental Services [List any additional benefits offered, such as routine dental care.]	[List co-pays / coinsurance]
[***Note:*** Include if applicable] Hearing Services [List any additional benefits offered, such as routine hearing care.]	[List co-pays / coinsurance]
[***Note:*** Include if applicable] Vision care [List any additional benefits offered, such as routine vision exams or glasses, unless included in "Vision Care" section	[List co-pays / coinsurance]

Benefits chart – your covered services	**What you must pay** when you get these covered services
earlier in benefits chart.]	
[***Note:*** Include if applicable] Health and wellness education programs [These are programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, smoking cessation, fitness, and stress management. Describe the nature of the programs here.]	[List co-pays / coinsurance]
[***Note:*** Include other additional benefits being offered]	[List co-pays / coinsurance]

All plans except PDP

Extra "optional supplemental" benefits you can buy

[***Note:*** Include this section if you offer optional supplemental benefits in the Plan. (You may include this section either in the EOC or as an insert to the EOC.)]

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

[***Note:*** Insert plan specific optional benefits, premiums, deductible, co-pays 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).]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

All plans except PDP, PFFS, MSAs, and ESRD-demonstration plans, insert next paragraph if applicable

Getting care using our Plan's traveler benefit

[***Note:*** If your plan offers traveler benefits to members who are out of your service area, adapt and expand the following paragraphs as needed to describe the traveler benefits and rules related to receiving 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) (from 7 through 12 months) also explain that here. Additionally, text may be modified to include a description of a visiting member program, if offered by plan.]

You may get care when you are outside the service area. You may need to pay higher cost sharing for routine care from non-network providers, but you won't pay extra in a medical emergency or if your care is urgently needed. If you have questions about your medical costs when you travel, please call Member Services.

PDP and MA-PD Plans

How Much You Pay for Part D Prescription Drugs

This section has a chart that tells you what you must pay for covered drugs. These are the benefits you get as a member of our Plan. (Covered Part B drugs were described earlier in this section, and later in this section under "General Exclusions" you can find information about drugs that are not covered.) For more detailed information about your benefits, please refer to our Summary of Benefits. If you do not have a current copy of the Summary of Benefits you can view it on our website or contact Member Services to request one.

How much do you pay for drugs covered by this Plan?

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., [deductible,] initial coverage period, the period after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described below. Refer to your plan formulary to see what drugs we cover [and what tier they are on]. (More information on the formulary is included later in this section.)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs." If you do not already qualify for extra help, see "Do you qualify for extra help?" in Section 1 for more information.

[Deductible]

[***Note to Plans with a deductible:*** insert "You will pay a yearly deductible of $[deductible amount]. OR [***Note to plans with a deductible on only a subset of drugs:*** insert "You will pay a yearly deductible of $[deductible amount] on [list of applicable drug tiers] drugs. For all other drugs you will not have to pay any deductible and will start receiving coverage immediately."] [After you meet the deductible, you will reach the initial coverage period.]

Initial Coverage Period

During the **initial coverage period**, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the [***Note:*** Plans insert either "coinsurance" OR "co-payment" OR "coinsurance or co-payment"]. Your [coinsurance/co-payment/coinsurance or copayment] will vary depending on the drug and where the prescription is filled.

You will pay the following for your covered prescription drugs:

*[**Note:*** If plan has any preferred pharmacies, the chart must be modified to reflect the appropriate member cost-sharing for preferred and non-preferred pharmacies. The Plan may also add tiers to the chart as necessary.]

[***Note**:* If a sponsor operates nationally or in multiple service areas, the chart may be modified to allow the option of indicating – either within the chart, or by reference to a separate chart – any variance in the cost-sharing levels for certain tiers for plans in different service areas.] [***Insert if applicable:*** "The benefits chart lists information for more than one of our Plans. The name of the plan you are in is listed on the front page of this packet. If you aren't sure which plan you are in or if you have any questions, call Member Services."]

[Drug Tier]	Network Retail Cost-	[Network Retail Cost-	Network Long-Term	[Network Mail-Order	[Network Mail-Order	Out-of-Network

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

	Sharing (<one month supply days>-day supply)	**Sharing (<extended day supply days>-day supply)]**	**Care Cost-Sharing (<one month supply days>-day supply)**	**Cost-Sharing (<one month supply days>-day supply)]**	**Cost-Sharing (<extended day supply days>-day supply)]**	**Cost-Sharing (<XX>-day supply)**
[Tier Name 1]	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount> [plus <insert differential>]
[Tier Name 2]	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount> [plus <insert differential>]
[Tier Name 3]	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount>	<cost-sharing amount> [plus <insert differential>]

Once your total drug costs reach $[ICL], you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this Plan, the amount they spend may count towards your initial coverage limit.

[We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs. [***Note:*** insert only if plan pays for OTC drugs as part of its administrative costs: "We also provide some over-the-counter medications exclusively for your use. These over-the-counter drugs are provided at no cost to you."] To find out which drugs our plan covers, refer to your formulary.]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Coverage Gap

[***Note:*** Insert either "After your total drug costs reach $[ICL] you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket costs reach $[TrOOP Amount], and you qualify for catastrophic coverage." OR "After your total drug costs reach $[ICL], we will continue to provide some prescription drug coverage until your total out-of-pocket costs reach $ [TrOOP Amount.]" [***Note:*** Plans offering coverage in the coverage gap must describe that coverage.]

Once your total out-of-pocket costs reach $[TrOOP amount], you will qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $[TrOOP amount] out-of-pocket for the year. When the total amount you have paid toward [your deductible,] [***Note:*** *Plan insert either:* "coinsurance" *OR* "co-payments" *OR* "coinsurance or co-payments",] and the cost for covered Part D drugs after you reach the initial coverage limit reaches $[TrOOP], you will qualify for catastrophic coverage. During catastrophic coverage you will pay: [the greater of 5% coinsurance or $[*Insert 2009 catastrophic cost-sharing amount for generics/preferred multisource drugs*] for generics or drugs that are treated like generics and $[*Insert 2009 catastrophic cost-sharing amount for all other drugs*] for all other drugs] *OR* [*Insert appropriate tiered cost-sharing amounts*]. We will pay the rest.

[***Note***: As mentioned earlier we offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your [deductible], initial coverage limit, or total out-of-pocket costs (that is, the amount you pay does not help you move through the benefit or qualify for catastrophic coverage).]

[Additional Benefits Information]

[***Optional****:* Insert any additional benefits information based on the plan's approved bid that is not captured in the sections above or in the exclusions section below.]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

Vaccine Coverage (including administration)

Our Plan's prescription drug benefit covers a number of vaccines, including vaccine administration. The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, following our out-of-network paper claims policy (see Section 2), and then you will be reimbursed up to our normal [coinsurance/co-payment/coinsurance or copayment] for that vaccine. In some cases you will be responsible for the difference between what we pay and what the out-of-network provider charges you. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

[Remember you are responsible for all of the costs associated with vaccines (including their administration) during the [deductible or] [coverage gap] phase[(s)] of your benefit.]

If you obtain the vaccine at:	**And get it administered by:**	**You pay (and/or are reimbursed)**
The Pharmacy	The Pharmacy (not possible in all States)	You pay your normal [coinsurance/co-payment/coinsurance or co-payment] for the vaccine.
Your Doctor	Your Doctor	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less your normal [coinsurance/co-payment/ coinsurance or co-payment] for the vaccine (including administration) [***Note:*** insert the following only if an out-of-network differential is charged "less any difference between the amount the Doctor charges and

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

		what we normally pay."*]
The Pharmacy	Your Doctor	You pay your normal [coinsurance/co-payment/coinsurance or co-payment] for the vaccine at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the amount charged by the doctor less any applicable in-network charge for administering the vaccine [***Note:*** insert the following only if an out-of-network differential is charged "less any difference between what the Doctor charges for administering the vaccine and what we normally pay."*]

*If you receive extra help, we will reimburse you for this difference.

[***Note*:** Insert any additional information about your coverage of vaccines and vaccine administration.]

We can help you understand the costs associated with vaccines (including administration) available under our Plan before you go to your doctor. For more information, please contact Member Services.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage as long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision on a coverage-determination request, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy), and otherwise meets our coverage requirements:

- [Your annual deductible];
- Your [***Note:*** Plan insert either "coinsurance" or "co-payments" or "coinsurance or co-payments"] up to the initial coverage limit
- Payments you made this year under another Medicare prescription drug plan prior to your enrollment in our plan

When you have spent a total of $[TrOOP amount] for these items, you will reach the catastrophic coverage level.

What type of prescription drug payments will not count toward your out-of-pocket costs?

[The amount you pay for your monthly premium doesn't count toward reaching the catastrophic coverage level. In addition,] [T/t]he following types of payments for prescription drugs **do not count** toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories
- Prescription drugs not covered by the Plan
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage
- [***Note****:* Insert only if plan does not provide coverage for excluded drugs as a supplemental benefit "Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare"]

[***Note:*** Insert next two bullets only if plan provides coverage for excluded drugs as a supplemental benefit.]

- [Prescription drugs covered by Part A or Part B]
- [Non-Part D drugs that are covered under our additional coverage but are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will also not count towards your initial coverage limit. There is information later in this section on the excluded non-Part D drugs we may cover as part of our additional coverage."]

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

[Except for your premium payments,] any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs and will help you qualify for catastrophic coverage:

- Family members or other individuals;
- [Qualified State Pharmacy Assistance Programs (SPAPs) (SPAPs have different names in different states. See Section 8 for the name and phone number for the SPAP in your area.)]
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following don't count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must let us know.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap or deductible period and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit documentation and have it count towards qualifying you for catastrophic coverage. In addition, for every month in which you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

All plan types

[***Note:*** Plans should include an example of the plan membership card, unless not available at time of printing.]

Sample plan membership card

Here is an example of what your plan membership card looks like. See Section 1 for more information on using your plan membership card. [Note: Insert Membership Card Diagram here

– front and back. Mark it as a sample card (for example, by superimposing the word “sample” on the image of the card)]

General Exclusions

All MA & MA-PD Plan Types

Introduction

The purpose of this part of Section 10 is to tell you about [medical care and services,] [items,] [and/or] [drugs] that aren’t covered (“are excluded”) or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes [services,] [items,] [and/or] [drugs] that aren’t covered under any conditions, [and some services that are covered only under specific conditions.] (The Benefits Chart earlier also explains about some restrictions or limitations that apply to certain services).

If you get [services, items AND/OR drugs] that are not covered, you must pay for them yourself

We won’t pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be [services,] [items,] [and/or] [drugs] that we should have paid or covered (appeals are discussed in Section 5).

All MA Plan Types and Cost Plans

What services are not covered or are limited by our Plan?

[***Note:*** You may add references to optional supplemental benefits where applicable, using the following format: However, [this item / these items] are available under Optional Supplemental Benefits.] [***Note to SNPs:*** Plans may, as appropriate, remove or modify language regarding benefit exclusions when the benefits are covered by the Plan under the Medicaid program, e.g., excluded drugs.]

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this EOC [Add mention of other places where exclusions are given, such as addenda], **the**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

following items and services aren't covered under the Original Medicare Plan or by our plan:

[***Note:*** The services listed in the remaining bullets are excluded from the Original Medicare benefit package. If any services below are covered supplemental benefits, delete them from this list. When plans partially exclude services excluded by Medicare they need not delete the item completely from the list of excluded services but may revise the text accordingly to describe the extent of the exclusion. Plans may also indicate if a service may be covered as an optional supplemental benefit.]

1. Services that aren't reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan.
4. Private room in a hospital, unless medically necessary.
5. Private duty nurses.
6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
7. Nursing care on a full-time basis in your home.
8. Custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
9. Homemaker services.
10. Charges imposed by immediate relatives or members of your household.
11. Meals delivered to your home.

PRA Disclosure Statement

12. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
13. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered.
15. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine,) and is limited according to Medicare guidelines.
16. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.
17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
18. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Hearing aids and routine hearing examinations.
20. Eyeglasses (except after cataract surgery), routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
21. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
23. Acupuncture.
24. Naturopath services.

[***Note:*** If you get a waiver from Medicare to exclude the limited abortion services covered by the Original Medicare Plan, you must provide the disclaimer in the bullet point below. List the specific services you won't provide and an alternative method (telephone number) for getting information on the covered services a member won't get based on moral or religious grounds.]

25. [Counseling or referral services that our Plan objects to based on moral or religious grounds. In the case of our Plan, we won't give counseling or referral services related to [enter the benefits for which you will not provide counseling or referral services, e.g., advance directives related to withholding nutrition/treatment, etc.]. To the extent these services are covered by Medicare, they will be covered under the Original Medicare Plan.]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average

500hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10260

26. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
27. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

PDP and MA-PD Plans

Excluded Drugs

This part of Section 10 talks about drugs that are "excluded," meaning they aren't normally covered by a Medicare drug plan. If you get drugs that are excluded, you must pay for them yourself. We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in Section 5).

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can't cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

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

[We offer additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan. [*Note*: Insert details about the excluded drugs your plan does cover, including whether you place any limits on that coverage.] The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage. In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs. Please refer to your formulary or call Member Services for more information.]

If you receive extra help, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

PRA Disclosure Statement

Index

[***Note:*** Paginate a word and phrase index so members can find specific content easily.]