Annual Notice of Change & Evidence of Coverage for Medicare Advantage Only Plans

[Insert date]

[Plans may add a greeting (e.g., Dear Member, Dear Mrs. [insert name]).]

Here are two documents with important information for you.

1. Please start by reading the **Notice of Changes for 2010**. It gives you a summary of changes to your benefits and costs for next year. These changes will take effect on January 1, 2010.

    - Please take a moment *very soon* to look through this summary and see how the changes might affect you.
    - If you decide to stay with *[insert plan name]* for 2010 – you do not have to tell us or fill out any paperwork. You will automatically remain enrolled as a member of *[insert plan name])*.
    - If you decide to leave *[insert plan name]*, you can switch to a different Medicare Advantage Plan or to Original Medicare from November 15 through December 31 each year. The *Notice of Changes* tells you more.

2. We're including a copy of next year's **Evidence of Coverage**. It's the legal, detailed description of your benefits and costs for 2010 if you stay enrolled as a member of *[insert plan name]*. It also explains your rights and rules you need to follow when using your coverage for medical care. Please look through this document so you know what's in it, then keep it handy for reference.

If you have questions, we're here to help. Please call Member Services at *[insert phone number]* (TTY/TDD only, call [*insert TTY/TDD number*]). Hours are *[insert days and hours of operation]* and calls to these numbers are [*insert as applicable:* free *OR not* free]. You can also visit our website, (*[insert URL]*).

We value your membership and hope to continue to serve you next year.

[Plans may add a closing (e.g., Sincerely) and signature.]

[Insert plan name] Notice of Changes for 2010

If you remain enrolled in *[insert plan name] for 2010,* there will be some changes next year to your benefits and what you pay

[*Plans may modify this introductory paragraph to tailor to its needs, as long as the paragraph is kept brief.*]

You are currently enrolled as a member of *[insert plan name]*. We are pleased to be providing your Medicare health care coverage. *[Plans that are consolidating, changing plan name or rolling over membership, as approved by CMS, in 2010, insert: (1) if changing the plan name, or consolidating other plans into the plan in which the beneficiary is enrolled —" We also want to let you know that we have changed our plan name from [insert previous plan name] to [insert new plan name] for the upcoming year." (2) if the beneficiary is being passively enrolled into another plan due to a consolidation or termination – "As we have explained, if you do not choose another plan, or choose to enroll in the Original Medicare Plan, you will be enrolled in the [insert plan name]. This notice describes changes in benefits from [insert previous plan name] to the [insert plan name] next year."]*

We're sending you this *Notice of Changes* to tell you how your benefits and costs as a member of *[insert plan name]* will change next year from your current benefits. The changes take effect on January 1, 2010. Medicare has approved these changes.

What should you do?

We want you to know what's ahead for next year, so **please read this document very soon to see how the changes in benefits and costs will affect you if you stay enrolled in** *[insert plan name]* **for 2010.**

To decide what's best for you, compare this information we're sending with the benefits and costs of other Medicare Advantage plans in your area and with Original Medicare. You can see what plans are available by visiting www.Medicare.gov. We hope to keep you as a member of *[insert plan name]*. But if you want to make a change for 2010, see *"When can you change"* in Section [X] for time periods when you can make a change.

We're here to help!

We are available for phone calls *[insert days and hours of operation]*. Calls to these numbers are *[insert if applicable: not]* free.

[Insert phone number]

[Insert TTY/TDD number] TTY/TDD only

[Plans may insert additional numbers, e.g., the plan's fax number or a number for callers who speak Spanish.]

Website: *[insert URL]*

Do you need large print or another format?

To get this material in other formats, including large type, Braille, and translations into other languages, call Member Services.

[Note: If section is deleted, update table of contents to reflect this change.]

Section 1. Important things to know

[Insert first subsection if plan is changing the plan name for the upcoming year:

Your plan name is changing for the upcoming year

Plans that are consolidating, changing plan name, or rolling over membership, insert: (1) if changing the plan name, or consolidating other plans into the plan in which the beneficiary is enrolled—We want to let you know that we have changed our plan name from [*insert previous plan name*] to [*insert new plan name*] for the upcoming year. Our phone numbers and address will remain the same; (2) if the beneficiary is being passively enrolled into another plan due to a consolidation or termination – "As we have explained, if you do not choose another plan, or choose to enroll in the Original Medicare Plan, you will be enrolled in the *[insert plan name]*. This notice describes changes in benefits from [*insert previous plan name]* to the *[insert plan name]* next year.*"]*

This *Notice of Changes* is only a summary (see your *Evidence of Coverage* for the details)

This *Notice of Changes* gives you a summary of the changes in your benefits and what you will pay for these services in 2010.

- To get the details, you can look in the 2010 *Evidence of Coverage* for *[insert plan name]*. The *Evidence of Coverage* is the legal, detailed description of your benefits and costs for 2010. It explains your rights and the rules you need to follow to get your covered service. (We have included a copy of the *Evidence of Coverage* in the same envelope with this *Notice of Changes*. If you do not have this copy, call Member Services.)
- If you have questions or need more information, you can always call Member Services (phone numbers are on the cover of this notice).

Section 2. Changes to your monthly premium

	2009 (this year)	**2010 (**next year)
Monthly premium	*[insert 2009 premium amount]*	*[insert 2010 premium amount]*

Section 3. Medical Services: Changes to your benefits and what you pay

[*If there are no changes in benefits or in cost-sharing, replace next two sections with:* Our benefits and what you pay for these covered services will be exactly the same in as it is in 2009.]

Changes to your benefits

[*If there are no changes in benefits but changes in cost-sharing, replace text and table below with:* Our benefits will be exactly the same in 2010 as it is in 2009. However, there are some changes in what you will pay for these covered services. See the next section for more information about the change in what you pay for covered services.]

As shown below, *[insert plan name]* is [*insert as appropriate:* adding [a] new benefit[s] *OR* ending [a] benefit[s] *OR* changing our covered benefits for] next year. For details, see Chapters 3 and 4 in your *Evidence of Coverage.*

[Plans list all new benefits that will be added or 2009 benefits that will be ended for 2010, including any new optional supplemental benefits and the premiums for those benefits.]

	2009 (this year)	**2010 (**next year)
[Insert benefit name]	*[insert 2009 benefit, e.g., "Not covered"]*	*[insert 2010 benefit, e.g., "Covered"]*

Changes to what you payer

[*If there are no changes in cost-sharing, replace text and table below with:* The amount you pay for covered services will be exactly the same in 2010 as they are in 2009.]

The chart below summarizes changes to what you will pay as your share of the cost of covered medical services. For details, see Chapter 4, *Medical benefits chart (what is covered and what you pay)*, in your *Evidence of Coverage.*

[Plans list all changes in cost-sharing for 2010 for covered medical services.]

	2009 (this year)	**2010** (next year)
***[Insert if applicable:]* Out-of-pocket maximum for medical services** *[Insert description of what OOP maximum applies to. E.g.: This maximum applies to what you pay as your share of the cost for your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) services.]*	*[insert 2009 OOP amount]*	*[insert 2010 OOP amount]*
[Insert benefit]	*[insert 2009 cost-sharing]* *[for coinsurance amounts add: (you pay xx% of the total cost)]*	*[insert 2010 cost-sharing]* *[for coinsurance amounts add: (you pay xx% of the total cost)]*
[Insert benefit]	*[insert 2009 cost-sharing]* *[for coinsurance amounts add: (you pay xx% of the total cost)]*	*[insert 2010 cost-sharing]* *[for coinsurance amounts add: (you pay xx% of the total cost)]*

Section [X]. What about changes to the plan's network of providers?

[Plans with no provider network delete this Section.]

Will your doctors and other providers still be in the plan's network next year?

There are a few changes to the network of providers for 2010. In addition, it's possible for the network of plan providers to change at any time during the year.

- **Please check with your doctors and other providers you currently use** to make sure they will continue to be part of the provider network for *[insert plan name]* in 2010.

- For the most up-to-date information on the network of providers, check our website (*[insert URL]*) or call Member Services (see phone numbers on the front cover).

Section [X]. What if I don't have drug coverage that is at least as good as Medicare's standard prescription drug coverage?

How do I know if I have drug coverage that is at least as good as Medicare's standard coverage?

Our plan does not include Medicare prescription drug coverage. If you haven't had other creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is at least as good as Medicare's standard 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 currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, your employer or retiree group should send you a notice by November 15 that tells if your prescription drug coverage is "creditable." If you received a notice this year that you no longer have creditable coverage, consider adding Medicare prescription drug coverage.

What are my options for getting Medicare prescription drug coverage?

If you would like to get Medicare prescription drug coverage, you have many plan options. [*MA plans offering other plans with Part D coverage, insert:* You can get Medicare prescription drug coverage by joining another Medicare Advantage plan that includes this coverage. Our organization offers the following plans that include Medicare drug coverage: [*insert list of plans with Part D coverage available in the service area and Member Services contact below*]]

To find other plans available in your area, visit www.medicare.gov and under "Search Tools" select either "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you join another Medicare Advantage plan or a Medicare drug plan, you will be disenrolled from our plan when your enrollment in the new plan begins.

Section [X]. Do you want to stay in the plan or make a change?

Do you want to stay with *[insert plan name]*?

If you want to keep your membership in *[insert plan name]* for 2010, it's easy. You don't need to tell us or fill out any paperwork. **You will automatically remain enrolled as a member.**

Do you want to make a change?

If you decide to leave *[insert plan name]*, you can switch to a different Medicare Advantage plan or to Original Medicare (either with or without a separate Medicare prescription drug plan).

If you want to change to a different plan, there are many choices. [*Insert if applicable:* As a reminder, *[insert plan name]* offers other Medicare Advantage plans in addition to the plan you are now enrolled in. These other plans may differ in coverage, monthly premiums, and cost sharing amounts.]

When can you change?

- During the **yearly enrollment period (called the "annual coordinated election period") from November 15 through December 31, 2009**, you can change to any other Medicare Advantage plan or to Original Medicare (either with or without a separate Medicare prescription drug plan). Your new coverage will begin on January 1, 2010.
- You also have **another, more limited enrollment period from January 1 through March 31, 2010.** During this period (called the "open enrollment period), you could switch to a different Medicare Advantage Plan without Part D prescription drug coverage or switch to Original Medicare. (You cannot enroll in a separate prescription drug plan during the Medicare Advantage Open Enrollment Period.) For more information about your choices during the January 1 through March 31 open enrollment period, please see Chapter 8, Section 2.2 of the *Evidence of Coverage.*

Are these the only times of year to choose a different plan?

For most people, yes. Certain individuals, such as those with Medicaid, or those who move out of the geographic service area, can make changes at other times. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage.*

How do you make a change?

See Chapter 8 of the enclosed *Evidence of Coverage* document. It tells what you need to do to make a change from *[insert plan name]* to another plan.

Things to check on before you make a change

- **Are you a member of an employer or retiree group?** If you are, please check with the benefits administrator of your group before you switch to another way of getting medical care.

Section [X]. Do you need some help? Would you like more information?

We have information and answers for you

To learn more, read the information we sent in the same package with this *Notice of Changes*. This includes a copy of the *Evidence of Coverage*.

If you have any questions, we are here to help. Please call us at *[insert plan name]* Member Services. We are available for phone calls *[insert days and hours of operation]*. Calls to these numbers are free: *[insert phone number]* (TTY/TDD only, call *[insert TTY/TDD number]*).

You can get help and information from your State Health Insurance Assistance Program

[*Organizations offering plans in multiple states: Revise this section to use the generic name ("State Health Insurance Assistance Program") when necessary, and include a list of names, phone numbers, and addresses for all SHIPs in your service area. Plans have the option of including a separate exhibit to list the SHIPs in all states, or in all states in which the plan is filed, and should make reference to that exhibit below.*]

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In *[insert state name]*, the State Health Insurance Assistance Program is called [*insert state-specific SHIP name*].

[*Insert state-specific SHIP name*] is independent (not connected with any insurance company or health plan). [*Insert state-specific SHIP name*] counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call [*insert state-specific SHIP name*] at [*insert phone number(s), including TTY/TDD number if available*].

You can get help and information from Medicare

Here are three ways to get information directly from Medicare:

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

- **Read *Medicare & You 2010.*** Every year in October, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227).

January 1 – December 31, 2010

Evidence of Coverage

This booklet is an important legal document for you to keep and use as a reference during 2010. It explains:

The details of your Medicare health coverage

How to get the care you need

[*Include plan contact information on the cover.]*

Table of Contents

This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a **detailed list of topics at the beginning of each chapter.**

CHAPTER 1: Getting started as a member of *[insert plan name]*

SECTION 1 Introduction

Chapter 1 Section 1.1 What is the *Evidence of Coverage* booklet about?

[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* booklet tells you how to get your Medicare medical care through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

- You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, *[insert plan name]*.
- There are different types of Medicare Advantage Plans. *[Insert plan name]* is a Medicare Advantage Plan HMO (HMO stands for Health Maintenance Organization).

In this *Evidence of Coverage*, the terms "we," "our," "the plan," "our plan," and "your plan," all refer to *[insert plan name]*.

The word "coverage" and "covered services" refers to the medical care and services available to you as a member of *[insert plan name]*.

Chapter 1 Section 1.2 What does this Chapter tell you?

Look through Chapter 1 of *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What materials will you get from us?
- What your plan premium is and how you can pay it?
- How to keep the information in your membership record up to date.

Chapter 1
Section 1.3

What if you are new to *[insert plan name]*?

If you are a new member, then it's important for you to learn how the plan operates – what the rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Member Services (contact information is on the cover of this booklet).

Chapter 1
Section 1.4

Legal information about *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how *[insert plan name]* covers your care. Other parts of this contract include your enrollment form and any notices you receive from *[insert plan name]* about changes or extra conditions that can affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in *[insert plan name]* between January 1, 2010 to December 31, 2010.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve *[insert plan name]* each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the *[insert plan name]* plan.

SECTION 2 What makes you eligible to be plan member?

Chapter 1
Section 2.1

Your *[insert number of requirements]* eligibility requirements

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

- You live in our geographic service area (section 2.3 below describes our service area)
- -- *and* -- you are entitled to Medicare Part A
- -- *and* -- you are enrolled in Medicare Part B
- -- *and* -- you do not have End Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- *[SNPs insert: -- and --* you meet the special eligibility requirements described below.]

[*SNPs insert this section as applicable to your plan type:*

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who [*insert as appropriate:* are eligible for both Medicare and Medicaid *OR* live in *[insert type of institution] OR* have *[insert chronic or disabling condition]*.

[*Chronic/disabling condition SNPs, insert:* Here is a list of the chronic or disabling condition[s] that meet the eligibility requirements for our plan.

[Insert list specifying the chronic or disabling condition(s), including specific lab values, if applicable, e.g., Total Blood Cholesterol exceeding 240mg without medication.]]]

Chapter 1
Section 2.2

What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, such as physician's services and other outpatient services.

To learn whether you have Medicare Part A and Part B, you can look on your red, white, and blue Medicare card. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227)
24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Chapter 1
Section 2.3

Here is the geographic service area for *[insert plan name]*

Although Medicare is a Federal program, *[insert plan name]* is available only to individuals who live in our geographic service area. To join our plan, you must live in this service area. To stay a member of our plan, you [*if a "continuation area" is offered under 42 C.F.R. 422.54, insert "generally" here, and add a sentence describing the continuation area*] must keep living in this service area. The service area is described [*insert as appropriate:* below *OR* in an appendix to this *Evidence of Coverage*.]

[*Insert plan services area here or within an appendix. Plans may include references to territories as a appropriate. Use county name only if approved for entire county. For partially approved counties, use county name plus zip code. Examples:*
Our service area includes these states: [*insert states*]
Our service area includes these counties in [*insert state*]: [*insert counties*]
Our service area includes these parts of counties in [*insert state*]: [*insert county*], the following zip codes only [*insert zip codes*]]

If you are not sure whether you live in the service area, or if you plan to move out of the service area, please contact Member Services.

SECTION 3 What other materials will you get from us?

Chapter 1
Section 3.1

Your plan membership card – Use it to get all covered medical care

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

While you are a member of our plan, you must use our membership card whenever you get any services covered by this plan. Here's a sample membership card to show you what yours will look like:

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

As long as you are a member of our plan **you must <u>not</u> use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research

studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: 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, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Chapter 1
Section 3.2

The *Provider Directory*: your guide to all providers in the plan's network

Every year that you are a member of our plan, we will send you either a new *Provider Directory* or an update to your *Provider Directory*. This directory lists our network providers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that participate in our plan. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, you may pay more for services you receive from an out-of-network provider. The only exceptions are emergencies, urgently needed care when the network is not available (generally, out of the area), out-of-area dialysis services, and cases in which *[insert plan name]* authorizes use of non-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

[Plans with a Point-of-Service (POS) option may briefly describe the POS option here. The details of the POS should be addressed in Chapter 3.]

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. [*Plans may add additional information describing the information available in the provider directory, on the plan's website, or from Member Services. For example:* You can also see the *Provider Directory* at [*insert URL*], or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.]

[Plans with a Point-of-Service option: briefly describe POS option here. The details of the POS should be addressed in Chapter 3.]

SECTION 4 Your monthly premium for *[insert plan name]*

Chapter 1 Section 4.1 How much is your plan premium?

[*Plans with a monthly premium*:] As a member of our plan, you pay a monthly plan premium. [*Select one of the following:* For 2010, the monthly premium for *[insert plan name]* is [*insert monthly premium amount*]. *OR* The table below shows the monthly plan premium amount for each region we serve. *OR* The monthly premium amount for *[insert plan name* is listed in [*describe attachment*].] [*Plans may insert a list of or table with the state/region and monthly plan premium amount for each area included within the EOC. Plans may also include premium(s) in an attachment to the EOC.*]

[Plans with no premium should replace the preceding paragraph with: You do not pay a separate monthly plan premium for *[insert plan name]*.]

[*Insert if applicable:* 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.]

In some situations, your plan premium could be more than [*insert monthly premium amount*]

[Plans that do not offer optional supplemental benefits may omit this subsection.]

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, please call Member Services.

Many members are required to pay other Medicare premiums

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

In addition to paying the monthly plan premium, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B.

- Your copy of *Medicare & You 2010* tells about these premiums in the section called "2010 Medicare Costs." This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2010* from http://www.medicare.gov. Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Chapter 1
Section 4.2

There are [*insert number of payment options*] ways you can pay your plan premium

There are [*insert number of payment options*] ways you can pay your plan premium. *[Plans must indicate how the member can inform the plan of their premium payment option choice and the procedure for changing that choice.]*

Option 1: You can pay by check

[*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 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.*]

Option 2: [*Insert option type*]

[*If applicable: Insert information about other payment options. Or delete this section.*

Include information about all relevant choices (e.g., automatically withdrawn from your bank account, charged directly to your credit card, charged directly to your debit card). Insert 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 [insert number]: You can have the plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up.

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the [*insert day of the month*]. If we have not received your premium by the [*insert day of the month*], we will send you a notice telling you that your plan membership will end if we do not receive your premium within [*insert length of plan grace period*].

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium. If we end your membership with the plan because of non-payment of premiums, and you don't currently have prescription drug coverage then you will not be able to receive Part D coverage until the annual election period. At this time, you may either join a stand-along prescription drug plan or a health plan that also provides drug coverage.

If we end your membership due to non-payment of premiums, you will have coverage under Original Medicare. *[Insert if applicable:* At the time we end your membership, you may still owe us for premiums you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay these late premiums before you can enroll.]

Chapter 1
Section 4.3

Can we change your monthly plan premium during the year?

[Plans without a monthly premium may delete this section.]

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in October and the change will take effect on January 1.

SECTION 5

Please keep your plan membership record up to date

Chapter 1
Section 5.1

How to help make sure that we have accurate information about you

[In the heading and this section, plans should substitute the name used for this file if different from "membership record."]

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage [*insert as appropriate:* including your Primary Care Provider/Medical Group/IPA].

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services are covered for you**. Because of this, it is very important that you help us keep your information up to date.

Call Member Services to let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are on the cover of this booklet).

CHAPTER 2: Important phone numbers and resources

SECTION 1 *[Insert plan name]* (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with enrollment, billing, or member card questions, please call or write to *[insert plan name]* Member Services. We will be happy to help you.

[Insert plan name] **Member Services**	
CALL	[*Insert phone number(s)*] Calls to this number are [*insert if applicable: not*] free. [*Insert hours of operation, including information on the use of alternative technologies.*]
TTY/TDD	[*Insert number*] This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are [*insert if applicable: not*] free. [*Insert hours of operation.*]
FAX	[*Insert fax number*]
WRITE	[*Insert address*] *[**Note**: plans may add email addresses here.]*
WEBSITE	[*Insert URL*]

*[**Note**: If your plan uses the same contact information for the Part C issues indicated below, you may combine the appropriate sections.]*

How to contact us when you are asking for a coverage decision about your medical care

[Insert plan name] **Coverage Decisions for Medical Care**	
CALL	[*Insert phone number*] Calls to this number are [*insert if applicable: not*] free. [***Note**: You may also include reference to 24-hour lines here.] [**Note**: If you have a different number for accepting expedited organization determinations, also include that number here.]*
TTY/TDD	[*Insert number*] This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are [*insert if applicable: not*] free. *[**Note**: If you have a different TTY/TDD number for accepting expedited organization determinations, also include that number here.]*
FAX	*[Optional: insert fax number] [**Note**: If you have a different fax number for accepting expedited organization determinations, also include that number here.]*
WRITE	*[Insert address] [**Note**: If you have a different address for accepting expedited organization determinations, also include that number here.]*

For more information on asking for coverage decisions about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

How to contact us when you making an appeal about your medical care

[Insert plan name] **Appeals for Medical Care**	
CALL	[*Insert phone number*] Calls to this number are [*insert if applicable: not*] free. [***Note**: You may also include reference to 24-hour lines here.] [**Note**: If you have a different number for accepting expedited appeals, also include that number here.]*

TTY/TDD	[*Insert number*] This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are [*insert if applicable: not*] free. *[**Note**: If you have a different TTY/TDD number for accepting expedited appeals, also include that number here.]*
FAX	*[Optional: insert fax number] [**Note**: If you have a different fax number for accepting expedited appeals, also include that number here.]*
WRITE	*[Insert address] [**Note**: If you have a different address for accepting expedited appeals, also include that number here.]*

For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

How to contact us when you are making a complaint about your medical care

[Insert plan name] **Complaints about Medical Care**	
CALL	[*Insert phone number*] Calls to this number are [*insert if applicable: not*] free. [***Note**: You may also include reference to 24-hour lines here.] [**Note**: If you have a different number for accepting expedited grievances, also include that number here.]*
TTY/TDD	[*Insert number*] This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are [*insert if applicable: not*] free. *[**Note**: If you have a different TTY/TDD number for accepting expedited grievances, also include that number here.]*
FAX	*[Optional: insert fax number] [**Note**: If you have a different fax number for accepting expedited grievances, also include that number here.]*
WRITE	*[Insert address] [**Note**: If you have a different address for accepting expedited grievances, also include that number here.]*

For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Where to send a request that asks us to pay for our share of the cost for medical care you have received

For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking the plan to pay its share of a bill you have received for medical services*).

[Insert plan name] **Payment Requests**	
CALL	[*Insert phone number*] Calls to this number are [*insert if applicable: not*] free.
TTY/TDD	[*Insert number*] This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are [*insert if applicable: not*] free.
FAX	[*Optional: Insert fax number*]
WRITE	[*Insert address*]

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

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

The Federal agency in charge of the Medicare program is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with and regulates Medicare health plans including *[insert plan name]*.

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	http://ww.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "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. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

SECTION 3 State Health Insurance Assistance Program

(free help, information, and answers to your questions about Medicare)

[*Organizations offering plans in multiple states: Revise this section to use the generic name ("State Health Insurance Assistance Program") when necessary, and include a list of names, phone numbers, and addresses for all SHIPs in your service area. Plans have the option of including a separate exhibit to list the SHIPs in all states, or in all states in which the plan is filed, and should make reference to that exhibit below.*]

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In [*insert state*], the State Health Insurance Assistance Program is called [*insert state-specific SHIP name*].

[*Insert state-specific SHIP name*] is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

[*Insert state-specific SHIP name*] counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. [*Insert state-specific SHIP name*] counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

[*Insert state-specific SHIP name*]	
CALL	[*Insert phone number(s)*]
TTY/TDD	[*Insert number, if available. Or delete this row.*] This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	[*Insert address*]
WEBSITE	[*Optional: Insert URL*]

SECTION 4 Quality Improvement Organization

(paid by Medicare to check on the quality of care for people with Medicare)

[*Organizations offering plans in multiple states: Revise this section to use the generic name ("Quality Improvement Organization") when necessary, and include a list of names, phone numbers, and addresses for all QIOs in your service area. Plans have the option of including a separate exhibit to list the QIOs in all states, or in all states in which the plan is filed, and should make reference to that exhibit below.*]

There is a Quality Improvement Organization in each state. In [*insert state*], the Quality Improvement Organization is called [*insert state-specific QIO name*].

[*Insert state-specific QIO name*] has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. [*Insert state-specific QIO name*] is an independent organization. It is not connected with our plan.

You should contact [*insert state-specific QIO name*] in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) care is ending too soon.

[*Insert state-specific QIO name*]	
CALL	[*Insert phone number(s)*]
TTY/TDD	[*Insert number, if available. Or delete this row.*] This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	[*Insert address*]
WEBSITE	[*Optional: Insert URL*]

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older , or who have a disability or end stage renal disease and meets certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare and pay the Part A premium. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call the Social Security or visit your local Social Security office.

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

SECTION 6 **Medicaid** (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

[*Organizations offering plans in multiple states: Revise this section to include a list of agency names, phone numbers, and addresses for all states in your service area. Plans have the option of including a separate exhibit to list Medicaid information in all states or in all states in which the plan is filed and should make reference to that exhibit below.*]

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

[SNPs may describe the Medicaid managed care program under which the organization contracts with the state Medicaid agency.]

[SNPs must, as appropriate, include additional telephone numbers for Medicaid program assistance, e.g., the telephone number for the state Ombudsman.]

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact [*insert state-specific Medicaid agency*].

[*Insert state-specific Medicaid agency*]	
CALL	[*Insert phone number(s)*]
TTY/TDD	[*Insert number, if available. Or delete this row.*] This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	[*Insert address*]
WEBSITE	[*Optional: Insert URL*]

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board	
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	http://www.rrb.gov

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

[SNPs may, as appropriate, delete this section since beneficiaries covered under employer groups are not eligible to participate in dual eligible SNPs in some states.]

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period.

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

CHAPTER 3: Using the plan's coverage for your medical services

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

This chapter tells things you need to know about using *[insert plan name]* to get your medical care. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

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

Chapter 3 **Section 1.1** What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

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

Chapter 3 **Section 1.2** Basic rules for getting your medical care that is covered by the plan

[Insert plan name] will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).

- **The care you receive is considered medically necessary**. It needs to be accepted treatment for your medical condition.
- *[Plans may omit or edit the PCP-related bullets as necessary]* **You have a primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a PCP (for more about this, see Section 2.1 in this chapter).
  - In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." For more about this, see Section 2.2 of this chapter.
  - Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more about this, see Section 2.3 of this chapter).
- *[Plans with a POS option may edit the network provider bullets as necessary.]* **You receive your care from a network provider** (for more about this, see Section 2 in this chapter). In most cases, care you receive from a non-network provider (a provider who is not part of our plan's network) will not be covered. *Here are two exceptions:*
  - Under certain circumstances, the plan covers emergency care or urgently needed care that you get from a non-network provider. For more about this, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from a non-network provider. In this situation, you will pay the same as you would pay if you got the care from a network provider.

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

Chapter 3 Section 2.1 You must choose a Primary Care Provider (PCP) to provide and arrange for your medical care

*[**Note**: Insert this section only if plan uses PCPs. Plans may edit this section to refer to a Physician of Choice (POC) instead of PCP.]*

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

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

- *What is a PCP?*

- *What types of providers may act as a PCP?*
- *Explain the role of a PCP in your plan.*
- *What is the role of the PCP in coordinating covered services?]*

How do you choose your PCP?

[Plans should describe how to choose a PCP.]

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

[Plans should describe how to change a PCP.]

[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.]

Chapter 3
Section 2.2

What kinds of medical care can you get without getting approval in advance from your PCP?

*[**Note**: Insert this section only if plan uses PCPs.]*

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

- 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 [*insert if applicable:* and pneumonia vaccinations] [*insert if appropriate:* as long as you get them from a network provider].
- Emergency services from network providers or from non-network providers.
- Urgently needed care from non-network providers when network providers are temporarily unavailable or inaccessible.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. [*Plans 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.]*
- *[Plans should add additional bullets as appropriate.]*

Chapter 3
Section 2.3

How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

[Plans should describe how members access specialists and other network providers, including:
- *What is the role (if any) of the PCP in referring members to specialists and other providers?*
- *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.]*

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

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. *[Plans should describe what to do if their specialist or other provider leaves the network.]*

[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.]

Chapter 3
Section 2.4

How to get care from out-of-network providers

[Plans with a POS option include Section 2.4. 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 the use of out-of-network providers in HMO/POS plans should be inserted here, with reference to the benefits chart where detailed information can be found.]

SECTION 3 **How to get covered services when you have an emergency or urgent need for care**

Chapter 3
Section 3.1

Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

When you have a "medical emergency," you believe that your health is in serious danger. A medical emergency can include 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 help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. *[Plans must provider either the number to call or explain where to find the number (e.g., on the back the plan membership card).]*

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. (In very limited circumstances emergency services are covered in Canada. If you have an emergency in Canada, call your plan to find out if you are eligible for coverage for emergency services.) Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the medical benefits chart in Chapter 4 of this booklet.

[Plans that offer a supplemental benefit covering emergencies or ambulance services outside of the country, mention the benefit here and then refer members to Chapter 4 for more information.]

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

[Plans may modify this paragraph as needed to address the post-stabilization care for your plan.] After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by non-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, we will generally cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- --*or*-- the additional care you get is considered "urgently needed care" and you follow the rules for getting this urgent care (for more about this, see Section 3.2 below).

Chapter 3
Section 3.2

Getting care when you have an urgent need for care

What is "urgently needed care"?

"Urgently needed care" is a non-emergency situation when:

- You need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger.
- Because of the situation, it isn't reasonable for you to obtain medical care from a network provider.

What if you are in the plan's service area when you have an urgent need for care?

Whenever possible, you must use our network providers when you are in the plan's service area and you have an urgent need for care. (For more about the plan's service area, see Chapter 1, Section 2.3 of this booklet.)

In most situations, if you are in the plan's service area, we will cover urgently needed care *only* if you get this care from a network provider and follow the other rules described earlier in this chapter. If the circumstances are unusual or extraordinary, and network providers are temporarily

unavailable or inaccessible, our plan will cover urgently needed care that you get from a non-network provider.

What if you are outside the plan's service area when you have an urgent need for care?

Suppose that you are temporarily outside our plan's service area, but still in the United States. If you have an urgent need for care, you probably will not be able to find or get to one of the providers in our plan's network. In this situation (when you are outside the service area and cannot get care from a network provider), our plan will cover urgently needed care that you get from any provider.

Our plan does not cover urgently needed care or any other care if you receive the care outside of the United States.

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

Chapter 3 Section 4.1 You can ask the plan to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you will want our plan to pay our share of the costs by reimbursing you for payments you have already made.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us so that we can pay our share of the costs for your covered medical services.

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7, Section 2.3 for information about what to do.

Chapter 3 Section 4.2 If services are not covered by our plan, you must pay the full cost

[Insert plan name] covers all medical services that are medically necessary and are covered under Medicare. You are responsible for paying the full cost of services that aren't covered by our plan.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services at the number on the front cover of this booklet to get more information about how to do this.

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. [*Plans should 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.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Chapter 3 **Section 5.1** What is a "clinical research study"?

A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, *you will be responsible for paying all costs for your participation in the study.*

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from our plan or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.
3. We can keep track of the health care services that you receive as part of the study.

If you plan on participating in a clinical research study, contact Member Services at *[insert phone number]* (TTY/TDD only, call [*insert TTY/TDD number*]). Hours are *[insert days and hours of operation]* and calls to these numbers are [*insert as applicable:* free *OR not* free].

Chapter 3
Section 5.2

When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, **Medicare will pay for the covered services you receive as part of the research study.** Medicare pays for routine costs of items and services. Examples of these items and services include the following:

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

When you are part of a clinical research study, **Medicare will *not* pay for any of the following**:

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your condition would usually require only one CT scan.

[*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 as a participant in the clinical research study. Because you are a member of our plan, you *do not* have to pay the deductibles for Original Medicare Part A or Part B.]

[If your plan 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 participants in a clinical trial sponsored by one of your contracting providers).]

Do you want to know more?

To find out what your coinsurance would be if you joined a Medicare-approved clinical research study, please call us at Member Services (phone numbers are on the cover of this booklet).

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" at http://www.medicare.gov/Publications/Pubs/pdf/02226.pdf. You can also call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Chapter 3 Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, you must elect to have your coverage for care in a religious non-medical health care institution. You may also chose at any time if for any reason you decide to pursue medical care. This benefit provides only for Part A inpatient services. Medicare will only pay for non-medical health care services furnished by religious non-medical health care institution.

Chapter 3 Section 6.2 What care from a religious non-medical health care institution is covered by our plan?

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if they are the kind of services that would ordinarily be given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following [*insert as applicable:* conditions apply *OR* condition applies]:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
    - *[Omit this bullet if not applicable]* – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

[*Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the benefits chart in Chapter 4) or whether there is unlimited coverage for this benefit.*]

CHAPTER 4: Medical benefits chart (what is covered and what you pay)

[SNPs may add a discussion to this chapter if they cover benefits under Medicaid, as long as the benefits are distinctly identified as Medicaid and not Medicare-covered benefits. This may include adding new language to the benefit chart itself as well as language to the related text in this chapter. This may be done in an additional column or additional rows or within existing cells of the chart or group together at the end and labeled as Medicaid benefits.]

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

This chapter focuses on your covered services and what your pay for you medical benefits. It includes a Medical Benefits Chart that gives a list of your covered services and tells how much you will pay for each covered service as a member of *[insert plan name]*. Later in this chapter, you can find information about medical services that are not covered. [*Insert if applicable:* It also tells about limitations on certain services.] *[If applicable, you may mention other places where benefits, limitations, and exclusions are described, such as optional additional benefits, or addenda.]*

Chapter 4 **Section 1.1** What types of out-of-pocket costs do you pay for your covered services?

[Describe all applicable cost-sharing types your plan uses. You may omit those that are not applicable.]

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The **"deductible"** means the amount you must pay for medical services before our plan begins to pay its share.
- A **"copayment"** means that you pay a fixed amount each time you receive a medical service. You pay a copayment at the time you get the medical service.
- **"Coinsurance"** means that you pay a percent of the total cost of a medical service. You pay a coinsurance at the time you get the medical service.

Some people qualify for programs to help them pay their out-of-pocket costs for Medicare. If you are enrolled in these programs, you may still have to pay the Medicaid copayment, depending on the rules in your state.

Chapter 4
Section 1.2

What is the maximum amount you will pay for certain covered medical services?

There is a limit to how much you have to pay out-of-pocket for certain covered health care services each year. [*Plans with out-of-pocket limit should describe what services the OOP max applies to, including dollar amounts. Plans may choose to do so using notations within the benefits chart.]*

[Section 2 should be deleted if the plan does not have an out-of-pocket limit.]

SECTION 2

Use this *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Chapter 4
Section 2.1

Your medical benefits and costs as a member of the plan

The medical benefits chart on the following pages lists the services *[insert plan name]* covers and what you pay for each service. The services listed in the Medical Benefits Chart are covered only when all coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Except in the case of preventative services and screening tests, your services (including medical care, services, supplies, and equipment) *must* be medically necessary. Medically necessary means that the services are an accepted treatment for your medical condition.
- [*Insert if applicable:* You receive your care from a network provider. In most cases, care you receive from a non-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from a non-network provider.]
- [*Insert if applicable:* You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.]
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from *[insert plan name]*. Covered services that need approval in advance

are marked in the Medical Benefits Chart [*insert as appropriate:* by an asterisk *OR* by a footnote *OR* in bold *OR* in italics*]* [*Insert if applicable:* In addition, the following services not listed in the Benefits Chart require prior authorization:

[*insert list*]]

[Instructions on completing benefits chart:

- *When preparing this Benefits Chart, please refer to any instructions contained in the cover memorandum of the standardized/combined ANOC/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.]*

Services that are covered for you	**What you must pay** when you get these services

Inpatient Care

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. *[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 companion.*]* *[Plans may further define the specifics of transplant travel coverage.]*
- 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.]*

[List copayments/ coinsurance. If cost-sharing is based on benefit period, include definition/ explanation of BID approved benefit period here. Plans that use a per-admission deductible, include: A per admission deductible is applied once during a benefit period.*]*

If you get *[insert if applicable:* 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.

Services that are covered for you		**What you must pay** when you get these services
• Physician Services		

Services that are covered for you	**What you must pay** when you get these 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 copays / coinsurance. If cost-sharing is based on benefit period, include definition/ explanation of BID approved benefit period here.]*
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") *[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.) • 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	*[List copays/ coinsurance. If cost-sharing is based on benefit period, include definition/explanation of BID approved benefit period here.]*

Services that are covered for you	**What you must pay** when you get these services
• Physician services 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 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	*[List copays / coinsurance]*
Home health agency care Covered services include:	*[List copays /*

Services that are covered for you	**What you must pay** when you get these services
• Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical social services • Medical equipment and supplies	*coinsurance]*
Hospice care You may receive care from any Medicare-certified hospice program. Original Medicare (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 Original Medicare • 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 Original Medicare, not *[insert plan name]*. *[Include information about cost-sharing for hospice consultation services if applicable.]*
Outpatient Services	
Physician services, including doctor's 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	*[List copays / coinsurance]*

Services that are covered for you	**What you must pay** when you get these services
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.]*	
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation *[Also list any additional benefits offered.]*	*[List copays / coinsurance]*
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 copays / 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	*[List copays / coinsurance]*

Services that are covered for you	**What you must pay** when you get these services
treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. *[Also list any additional benefits offered.]*	
Outpatient substance abuse services	*[List copays / coinsurance]*
Outpatient surgery, including services provided at ambulatory surgical centers	*[List copays / coinsurance]*
Ambulance services Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.	*[List copays / 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 copays / coinsurance. If applicable, explain that cost-sharing is waived if member admitted to hospital.]* If you need inpatient care at an out-of-network hospital after your emergency condition is stabilized, *[Insert one or both:*

Services that are covered for you	**What you must pay** when you get these services
	you must return to a network hospital in order for your care to continue to be covered *OR* you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the *[Insert if applicable:* highest*]* cost-sharing you would pay at a network hospital.*]*
Urgently needed care *[Include in-network benefits. Also identify whether this coverage is within the U.S. or world-wide.]*	*[List copays / coinsurance. Plans should include different copayments for contracted urgent care centers, if applicable.]*
Comprehensive Outpatient Rehabilitation Facility (CORF) service Covered services include: Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy	*[List copays / coinsurance]*
Durable medical equipment and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.	*[List copays / coinsurance]*

Services that are covered for you	**What you must pay** when you get these services
Prosthetic devices and related supplies Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	*[List copays / coinsurance]*
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 custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). For people with diabetes who have severe diabetic foot disease, coverage includes fitting. • 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 copays / 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 copays / coinsurance]*
Outpatient diagnostic tests and therapeutic services and supplies Covered services include:	*[List copays / coinsurance]*

Services that are covered for you	**What you must pay** when you get these services
• X-rays • Radiation therapy *[List separately any services for which a separate copay/coinsurance applies over and above the outpatient radiation therapy copay/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]*	
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 Original Medicare.]* 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 copays / coinsurance]*
Preventive Care and Screening Tests	

Services that are covered for you	**What you must pay** when you get these services
[*For all preventive care and screening test benefit information, plans that cover a richer benefit than Original Medicare do not need to include given description (unless still applicable) and may instead describe plan benefit.*] **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan 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.*]	[*List copays/ coinsurance*]
"Welcome to Medicare" exam Welcome to Medicare exam (covered during the first 12 months that the enrollee has Medicare Part B). The reimbursement for this benefit does not include reimbursement for EKGs, clinical laboratory tests, as well as screening and other preventative services currently covered under Medicare Part B *[Also list any additional benefits offered.]*	[*List copays/ coinsurance*]
Bone mass measurement 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 copays/ 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:	*[List copays / coinsurance]*

Services that are covered for you	**What you must pay** when you get these services
• 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.]*	
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 We also cover some vaccines under our outpatient prescription drug benefit. *[Also list any additional benefits offered.]*	*[List copays / 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 copays / coinsurance]*
Pap test, pelvic exams, and clinical breast exams 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	*[List copays / coinsurance]*

Services that are covered for you	**What you must pay** when you get these services
[Also list any additional benefits offered.]	
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 copays / 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 copays / coinsurance]*
Physician exams [*Plans that cover only what Original Medicare covers insert*: A one-time physical exam for members within the first 12 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 copays / coinsurance]*
Other Services	
Dialysis (kidney) Covered services include: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area) • 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	*[List copays / coinsurance]*

Services that are covered for you	**What you must pay** when you get these services
• 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)	
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • 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 • 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, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases *[MA only plans delete the following paragraph.]* Chapter 5 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 in Chapter 6.	*[List copays / coinsurance]*
Additional Benefits	

Services that are covered for you	**What you must pay** when you get these services
[For all additional benefits information, plans should include only applicable rows.] **Dental services** *[List any additional benefits offered, such as routine dental care.]*	*[List copays / coinsurance]*
Hearing services *[List any additional benefits offered, such as routine hearing care.]*	*[List copays / coinsurance]*
Vision care *[List any additional benefits offered, such as routine vision exams or glasses, unless included in "Vision Care" section earlier in benefits chart.]*	*[List copays / coinsurance]*
Health and wellness education programs *[These are programs focused on clinical health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, smoking cessation, fitness, and stress management. Describe the nature of the programs here.]*	*[List copays / coinsurance]*
[Include other additional benefits being offered.]	*[List copays / coinsurance]*

Chapter 4
Section 2.2

Extra "optional supplemental" benefit you can buy

[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 Original Medicare 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 [*insert if applicable:* 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.

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

Chapter 4
Section 2.3

Getting care using our plan's traveler benefit

[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.

SECTION 3 What types of *benefits* are not covered by the plan?

Chapter 4
Section 3.1

Types of benefits we do *not* cover

[Plans may add references to optional supplemental benefits where applicable, using the following format: However, [insert item/items] are available under Optional Supplemental Benefits.]

[SNPs may, as appropriate, remove or modify language regarding benefit exclusions when the benefits are covered by the plan under the Medicaid program.]

This section tells you what kinds benefits are "excluded." Excluded means that the plan doesn't cover these benefits.

The list below describes some services and items that aren't covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, [*mention any other places where exclusions are given, such as addenda,]* **the following items and services aren't covered under Original Medicare or by our plan:**

[*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.]*

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as a covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study. See Chapter 3, Section 5 for more information on clinical research studies.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.

- Homemaker services provide basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, filings or dentures. However, non-routine dental care received at a hospital may be covered.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Hearing aids and routine hearing examinations.
- Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
- Prescription drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan. We will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Any services listed above that aren’t covered will remain not covered even if received at an emergency facility.

CHAPTER 5: Asking the plan to pay its share of a bill you have received for medical services

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

Chapter 5 **Section 1.1** If you pay our plan's share of the cost or if you receive a bill for your covered services, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

When you receive emergency or urgently needed care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

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

[Plans should insert additional circumstances under which they will accept a paper claim from an enrollee.]

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

Chapter 5 Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

[*If the plan has developed a specific form for requesting payment, insert the following language:* To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it's helpful.
- Either download a copy of the form from our website ([*insert URL*]) or call Member Services and ask for the form. The phone numbers for Member Services are on the cover of this booklet.]

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

[*insert address*]

Please be sure to contact Member Services if you have any questions. If you don't know what you owe, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

Chapter 5 Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services.)
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested.

Chapter 5 Section 3.2 If we tell you that we will not pay for the medical care, you can make an appeal

If you think we have made a mistake in turning you down, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a legal process with complicated procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” Then after you have read Section 4, you can go to the Section 5.4 to learn how to make an appeal about getting paid back for a medical service.

CHAPTER 6: Your rights and responsibilities

SECTION 1. Our plan must honor your rights as a member of the plan

SECTION 2. You have some responsibilities as a member of the plan

SECTION 1 Our plan must honor your rights as a member of the plan

Chapter 6 Section 1.1 We must provide information in a way that works for you (in languages other than English, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services (phone numbers are on the front cover).

Our plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in large print or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Chapter 6 Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

If you want more information or have concerns about discrimination or unfair treatment, please call the Federal government's **Office for Civil Rights** 1-800-368-1019 (TTY/TDD 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are on the cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Chapter 6 Section 1.3 We must ensure that you get timely access to your covered services

As a member of our plan, you have the right to choose a [*insert as appropriate:* primary care provider (PCP) *OR* provider] in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Members Services to learn which doctors are accepting new patients (phone numbers are on the cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

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

Chapter 6 Section 1.4 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

- For example, we are required to release health information to government agencies that are checking on quality of care.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are on the cover of this booklet).

*[**Note:** Plans may insert custom privacy practices.]*

Chapter 6
Section 1.5

We must give you information about the plan, its network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are on the cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.
- **Information about our network providers.**
  - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
  - For a list of the providers in the plan's network, see the *Provider Directory*.

- For more detailed information about our providers, you can call Member Services (phone numbers are on the cover of this booklet) or visit our website at [*insert URL*].

- **Information about your coverage and rules you must follow in using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are on the cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
  - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Chapter 6
Section 1.6

We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

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

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

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** 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. [*Insert if applicable:* You can also contact Member Services to ask for the forms (phone numbers are on the cover of this booklet).]
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form 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. Be sure to keep a copy at home.

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

- 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.

What if your instructions are not followed?

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 [*insert appropriate state-specific agency (such as the State Department of Health)*]. [***Note:** Plans that would like to provide members with state specific information about advanced directives may do so.*]

Chapter 6
Section 1.7

You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are on the cover of this booklet).

Chapter 6
Section 1.8

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

If it is about discrimination, call the Office for Civil Rights

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Federal government's **Office for Civil Rights** at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, turn to Chapter 2 of this booklet and look for Section 3.

Chapter 6
Section 1.9

How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, turn to Chapter 2 of this booklet and look for Section 3.
- You can contact **Medicare**.
    - You can visit http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf to read or download the publication "Your Medicare Rights & Protections."
    - Or, you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 Your responsibilities as a member of the plan

Chapter 6 Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are on the cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- **If you have any other health insurance coverage or prescription drug coverage besides our plan, you are required to tell us.** Please call Member Services to let us know.
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other benefits available to you. We'll help you with it.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - [*Insert if applicable:* You must pay your plan premiums to continue being a member of our plan.]
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a [*insert as appropriate:* copayment (a fixed amount) *OR* coinsurance (a percentage of the total cost) *OR* copayment (a fixed amount) or coinsurance (a percentage of the total cost)]. Chapter 4 of this booklet tells what you must pay for your medical services.
  - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.

- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are on the cover of this booklet).
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.

- **Call member services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are on the cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2 of this booklet.

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

Background

SECTION 1. Introduction

SECTION 2. You can get help from government organizations that are not connected with our plan

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

Coverage decisions and appeals

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

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

Background

SECTION 1 **Introduction**

Chapter 7
Section 1.1

What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call us at Member Services (phone numbers are on the cover of this booklet). We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

This chapter explains two types of formal processes for handling problems:

- For some types of problems, you need to use the **process for coverage decisions and making appeals**.
- For other types of problems you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Chapter 7
Section 1.2

What about the legal terms?

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

To keep things simple, this chapter explains the legal rules and procedures using more common words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

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

SECTION 2 You can get help from government organizations that are not connected with our plan

Chapter 7
Section 2.1

Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

Get help from an independent government organization

Our plan is always available to help you. But in some situations you may also want help or guidance from someone who is not part of our plan. You can always contact your **State Health Insurance Assistance Program**. This government program has trained counselors in every state. The program is not connected with our plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

Their services are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

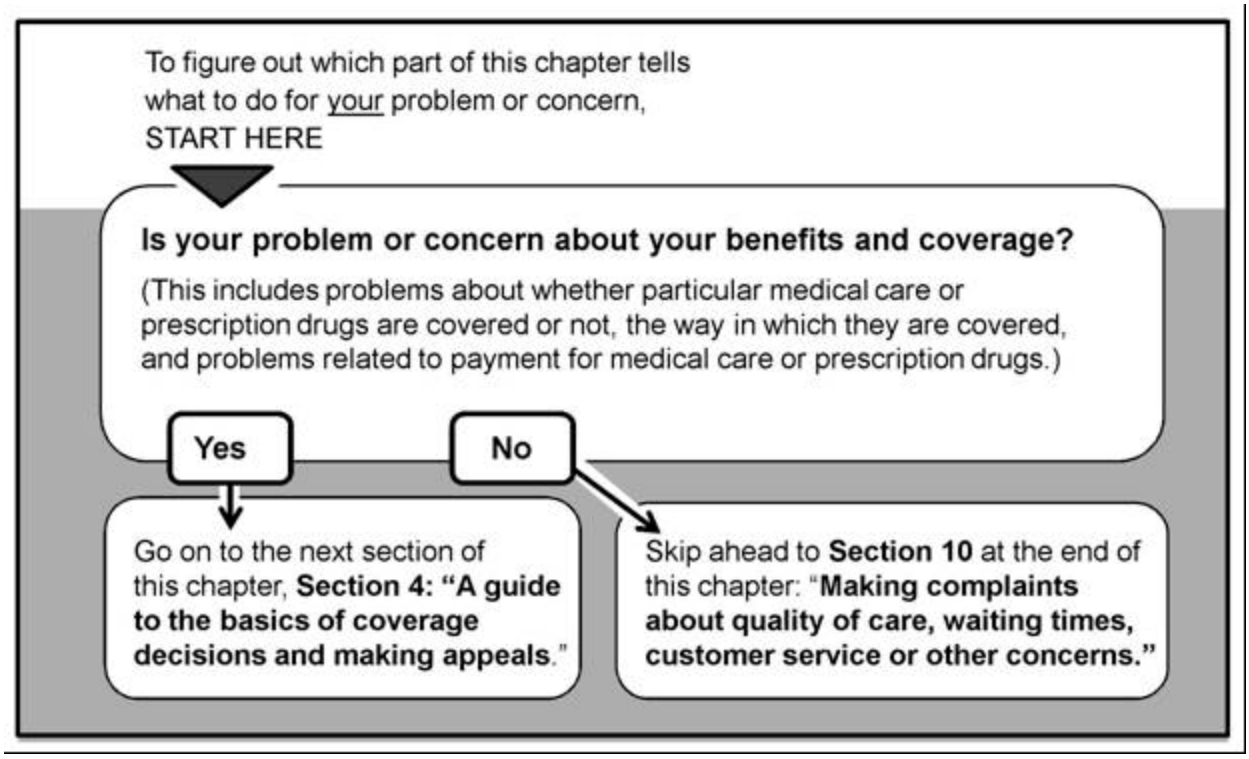
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

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

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

Chapter 7 Section 3.1 Should you use the process for coverage decisions and appeals? Or the process for making complaints?

If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.



Coverage decisions and appeals

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

Chapter 7
Section 4.1

Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision our plan makes about your benefits and coverage or about the amount we will pay for your medical services. You ask us for a coverage decision whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the service is covered and pay our share of the cost.
- But in some cases we might decide the services are not covered for you. Or we may decide it is time to stop covering services you have been receiving. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If our plan makes a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking our plan to review and change a coverage decision we have made.

When you make an appeal, our plan reviews the coverage decision we have made to check to see if our plan was being fair and following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through several more levels of appeal.

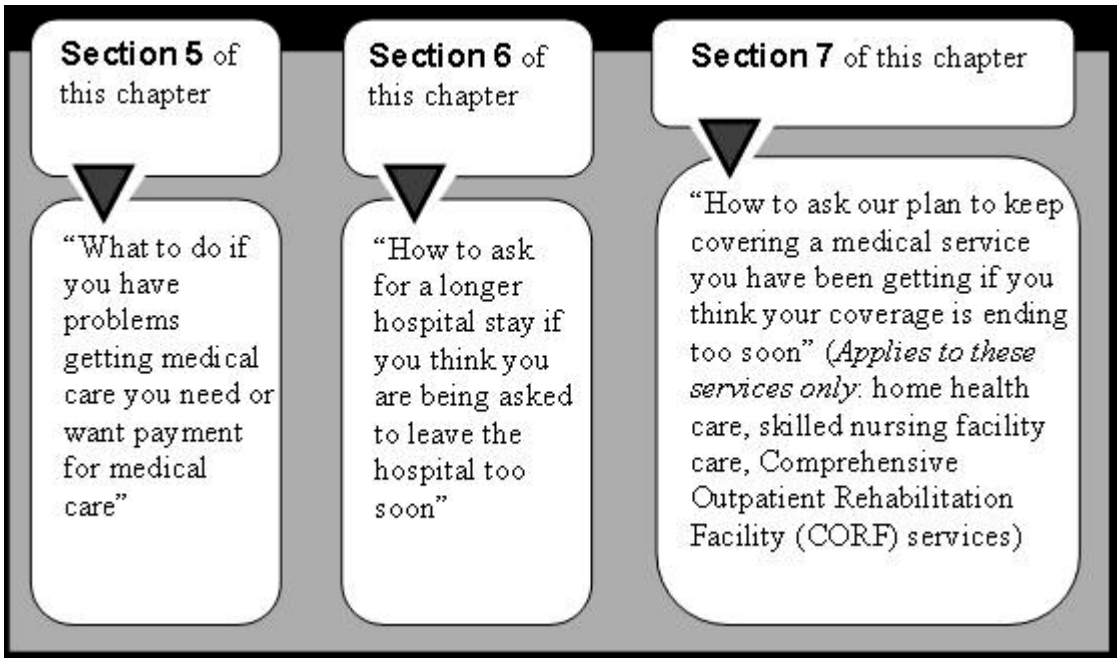
Chapter 7 **Section 4.2** How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are on the cover).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **You can, and probably need to, get your doctor involved.** In most situations involving a coverage decision or appeal, your doctor must explain the medical reasons that support your request.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor, or other person to be your representative, call Member Services and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.
- **You also have the right to hire 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. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Chapter 7 **Section 4.3** Which section of this chapter gives the details for <u>your</u> situation?

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



If you're still not sure which section you should be using, please call Member Services (phone numbers are on the front cover). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

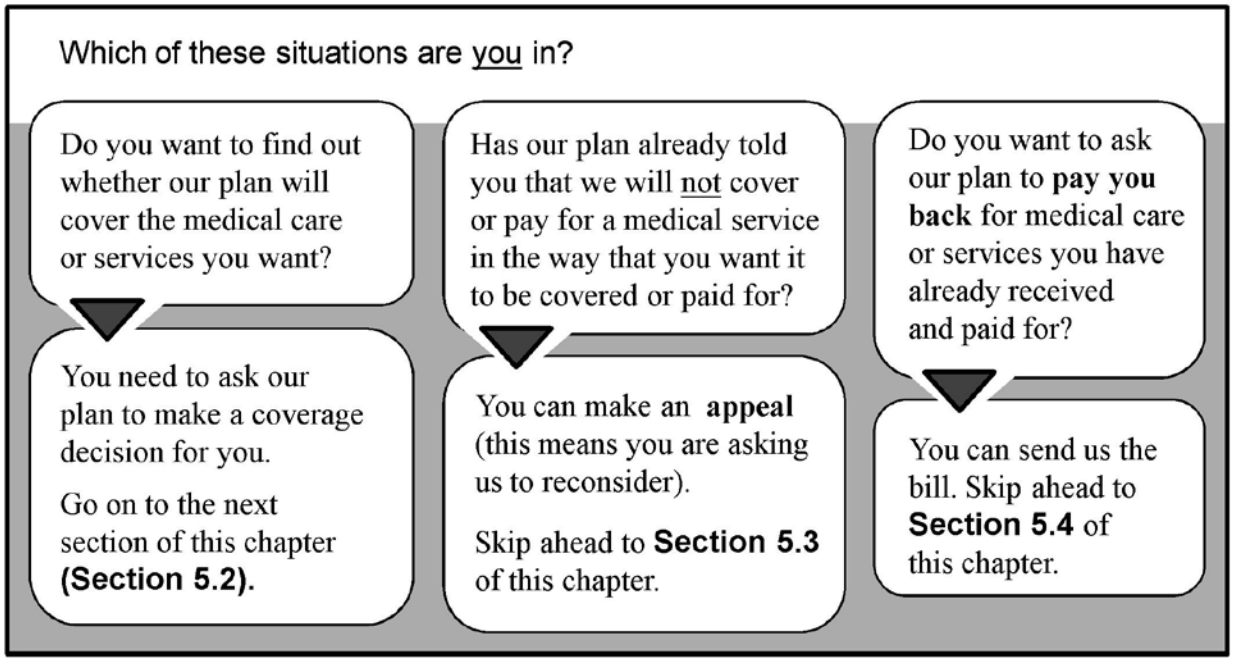
Chapter 7
Section 5.1

This section tells what to if you have problems getting medical care or if you want us to pay you back for medical care

This section is about your benefits for medical care and services. These are the benefits described in Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay*). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that certain medical care you have been getting will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
    - NOTE: **If the care that will be stopped is hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
        - Chapter 7, Section 6: *How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
        - Chapter 7, Section 7: *How to ask our plan to keep covering a medical service you have been getting if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and comprehensive outpatient rehabilitation facility (CORF) care.
    - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.



Chapter 7
Section 5.2

Step-by-step how to ask for a coverage decision
(how to ask our plan to authorize or provide the medical care coverage you want)

Legal terms

A coverage decision is called an "**initial determination**" or "initial decision." When a coverage decision involves your medical care, the initial determination is called an "**organization determination**."

Step 1 ➔ **You ask our plan to make a coverage decision on the medical care you are requesting.** If your health requires a quick response, you must ask us to make a **"fast decision."**

Legal terms

A "fast decision" is called an "**expedited** decision."

How to request coverage for the medical care you want

- Start by [*insert if applicable:* calling,] writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.

- For the details on how to contact us, including how to reach us on evenings and weekends, go to Chapter 2, Section 1 and look for the section called, *[plans may edit section title as necessary] How to reach our plan when you are asking for a coverage decision about your medical care.*

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a "fast decision"

- **A fast decision means we will answer within 72 hours.**
  - **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 decide to take extra days, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for medical care *you have not yet received*. (You cannot get a fast decision if your request is about medical care you have already received.)
  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor's support, our plan will decide whether your health requires that we give you 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 that says so (and we will use the standard deadlines instead).
- This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Step 2 ➔ Our plan considers your request for medical care coverage and we give you our answer.

Deadlines for a "**fast**" coverage decision

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more days under certain circumstances. If we take extra days, it is called "an extended time period."
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

Deadlines for a "**standard**" coverage decision

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request.**
  - We can extend the time up to 14 more days ("an extended time period") under certain circumstances.
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 14 days. If we extended the time needed

to make our decision, we will provide the coverage by the end of that extended period.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3 ➔ If we say no to your request for coverage for medical care, you decide if you want to make an appeal

- If our plan says no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Chapter 7
Section 5.3

Step-by-step: How to make a Level 1 Appeal
(how to ask for a review of a medical care coverage decision made by our plan)

Legal terms

When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

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

Step 1 ➔ You contact our plan and make your appeal.

If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start your appeal, you (or your doctor or your representative) must contact our plan.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, *[plans may edit section title as necessary]How to reach our plan when you are making an appeal about your medical care.*
- **Make your appeal in writing by submitting a signed request.** [*If the plan accepts oral requests for standard appeals, insert:* You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 *[plans may edit section title as necessary]* (*How to reach our plan when you are making an appeal about your medical care*).]

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- **You can ask for a copy of the information in your appeal and add more information if you like.**
  - You have the right to ask us for a copy of the information regarding your appeal. [*If a fee is charged, insert:* We are allowed to charge a fee for copying and sending this information to you.]
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

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

- If you are appealing a decision our plan made about care you have not yet received, you and your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast decision." To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section).

Step 2 ➔ Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were being fair and following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "**fast**" **appeal**

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more days.**

- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours**.**
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

Deadlines for a "**standard**" **appeal**

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more days.**
  - If we do not give you an answer within 30 days (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3 ➔ If our plan says no to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were being fair when we said no to your appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

If our plan says no to your level 1 appeal, your case will *automatically* be sent on to the next level of the appeals process. During the level 2 appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal terms

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1 ➔ The Independent Review Organization reviews your appeal

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. [*If a fee is charged, insert:* We are allowed to charge you a fee for copying and sending this information to you.]
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

Deadlines for a "**fast**" **appeal**

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.

Deadlines for a "**standard**" **appeal**

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.

Step 2 ➔ The Independent Review Organization gives you their answer

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must provide the medical care coverage that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.

- **If this organization says no to your appeal**, it means they agree with our plan that your request for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- Appeal Level 3 is handled by a judge. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Chapter 7
Section 5.5

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

If you want to ask our plan for payment for medical care, start by reading Chapter 7 of this booklet: *Asking the plan to pay its share of a bill you have received for medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from our plan

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical benefits chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you think we have made a mistake in turning you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, the **standard deadlines** apply to all parts of the appeals process. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- At any stage of the appeals process, if the answer to your appeal is yes, then our plan must send the payment you have requested. We are required to send payment to you or to the provider **within 30 days**.

SECTION 6 How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about the plan's coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay)*.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**." Our plan's coverage of your hospital stay ends on this date.

- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Chapter 7
Section 6.1

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

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital is supposed to give it to you within two days after you are admitted.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - What to do if you think you are being discharged from the hospital too soon.

The written notice from Medicare tells you how you can **"make an appeal."** Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time. (Section 6.2 below tells how to make this appeal.)

2. **You must sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1-800-633-4227 or TTY: 1-877-486-2048). You can also see it online at http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage

Chapter 7
Section 6.2

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

If you want to ask for your hospital services to be covered by our plan for a longer time, you will need to use the appeals process to make this request. For general information about the appeals process, see Section 4 of this chapter. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

Step 1 ➔ Contact the Quality Improvement Organization in your state and ask for a **"fast review"** of your hospital discharge. You must **act quickly**.

A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
    - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
    - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.3.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our plan has given to them.
- During this review process, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our plan think it is right (medically appropriate) for you to be discharged on that date.

This written explanation is called the "**Detailed Notice of Discharge."** (You can get a sample of this notice by calling Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) Or, you can get see a sample notice online at www.cms.hhs.gov/BNI/).

Step 3 ➔ **Within one full day** after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **our plan must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying *no* to your appeal is also called *turning down* your appeal.) If this happens, **our plan's coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4 ➔ If the answer to your Level 1 appeal is no, you decide if you want to make another appeal

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Chapter 7
Section 6.3

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Here are the steps for Level 2 of the appeal process:

Step 1 ➔ You contact the Quality Improvement Organization again and **ask for another review**

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2 ➔ The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3 ➔ **Within 14 days**, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **Our plan must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **Our plan must continue providing coverage** for your hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made to your Level 1 appeal and will not change it. This is called “upholding the decision.” It is also called “turning down your appeal.”

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4 ➔ If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Chapter 7
Section 6.4

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

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

Step-by-Step: How to make a Level 1 *Alternate* Appeal If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal terms

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

Step 1 ➔ Contact our plan and ask for a "fast review."

- For details on how to contact our plan (including how to reach us on evenings and weekends), go to Chapter 2, Section 1 and look for the section called, *[plans may edit section title as necessary] How to reach our plan when you are making an appeal about your medical care.*

- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2 ➔ Our plan does a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, our plan takes a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3 ➔ Our plan gives you our decision **within 72 hours** after you ask for a "fast review" ("fast appeal").

- **If our plan says yes to your fast appeal,** it means we have agreed to keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our plan says no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services will end on that date and our plan will stop paying its share of the costs of this care.
- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date. You will be responsible for the cost of care starting from noon on the day after our plan says no to your appeal.

Step 4 ➔ If our plan says *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were being fair when we said no to your fast appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If our plan says no to your level 1 appeal, your case will *automatically* be sent on to the next level of the appeals process. During the level 2 appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1 ➔ Our plan asks the Independent Review Organization to conduct a **"fast review"** of your case. (Our plan asks for this review on your behalf.)

- We are required to send the information for your Level 2 appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2 ➔ The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer **within 24 hours**.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with our plan that your planned hospital discharge date was medically appropriate. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will

give you the details about how to go on to Appeal Level 3, which is handled by a judge.

Step 3 ➔ If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

Chapter 7
Section 7.1

This section is about three services only:

Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, *Definitions of important words.*)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay).*

When our plan decides it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *our plan will stop paying its share of the cost for your care.*

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to appeal.

Chapter 7
Section 7.2

We tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
   - The written notice tells you the date when our plan will stop covering the care for you.

     Legal terms

     In this written notice, we are telling you about a **"coverage decision"** we have made about when to stop covering your care. (For more about coverage decisions, see Section 4 in this chapter.)

   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

     Legal terms

     In telling what you can do, the written notice is telling how you can **"make an appeal."** Making an appeal is a formal, legal way to ask our plan to change the coverage decision we have made about when to stop your care. (Section 7.3 below tells how you can make an appeal.)

     Legal terms

     The written notice is called the "**Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at http://www.cms.hhs.gov/BNI/.

2. **You must sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Chapter 7
Section 7.3

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

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. For general information about the appeals process, see Section 4 of this chapter. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

When you start the appeal process by making an appeal, it is called the "first level of appeal" or "Level 1 Appeal."

Step 1 ➔ **Make your Level 1 Appeal:** contact the Quality Improvement Organization in your state and ask for a review. **You must act quickly**.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for our plan to end coverage for your medical services.

Deadline.

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day before the date that your coverage ends.
  - If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- During this review process, you will also get a written notice from the plan that gives our reasons for wanting to end the plan's coverage for your services.

This written notice is called the "**Detailed Explanation of Non-Coverage.**"

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

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **our plan must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** Our plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or outpatient rehabilitation care *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4 ➔ If the answer your Level 1 appeal is no, you decide if you want to make another appeal

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Chapter 7
Section 7.4

Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Here are the steps for Level 2 of the appeal process:

Step 1 ➔ You contact the Quality Improvement Organization again and ask for another review

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2 ➔ The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3 ➔ **Within 14 days**, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **Our plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Our plan must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision they made to your Level 1 appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4 ➔ If the answer is no, you will need to decide whether you want to take your appeal further

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Chapter 7
Section 7.5

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

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

Step 1 ➔ Contact our plan and ask for a "fast review."

- For details on how to contact our plan (including how to reach us on evenings and weekends), go to Chapter 2, Section 1 and look for the section called, *[plans may edit section title as necessary] How to reach our plan when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2 ➔ Our plan does a "fast" review of the decision we made about when to stop coverage for your services.

- During this review, our plan takes another look at all of the information about your case. We check to see if we were being fair and following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3 ➔ Our plan gives you our decision **within 72 hours** after you ask for a "fast review" ("fast appeal").

- **If our plan says yes to your fast appeal,** it means we have agreed to keep providing your covered services for as long as it is medically necessary. It also means that we have

agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If our plan says no to your fast appeal,** then your coverage will end on the date we have told you and our plan will not pay after this date. Our plan will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or comprehensive outpatient rehabilitation care (CORF) *after* the date when we said your coverage would your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4 ➔ If our plan says *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were being fair when we said no to your fast appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If our plan says no to your level 1 appeal, your case will *automatically* be sent on to the next level of the appeals process. During the level 2 appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1 ➔ Our plan asks the Independent Review Organization to conduct a **"fast review"** of your case. (Our plan asks for this review on your behalf.)

- We are required to send the information for your Level 2 appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2 ➔ The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer **within 24 hours**.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it. (This is called "upholding the decision" It is also called "turning down your appeal.")
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to Appeal Level 3.

Step 3 ➔ If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

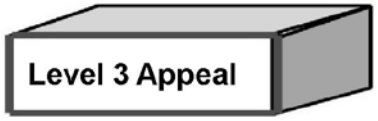
Chapter 7
Section 8.1

Levels of Appeal 3, 4, and 5

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

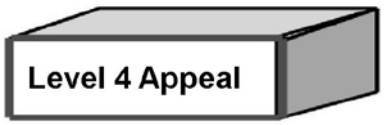
If the dollar value of the drug or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

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



A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

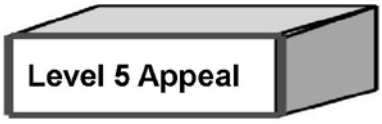
- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.



The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you

to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.



A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process. The decision of the Federal Court is final.

- This is the last stage of the appeals process. The Level 5 Appeal decision is final.

Making complaints

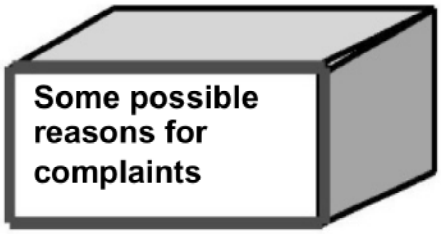
[SNPs should revise the following language, as appropriate to incorporate information about the processes available to beneficiaries to pursue grievances related to Medicaid-covered services.]

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

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Chapter 7 **Section 9.1** What kinds of problems are handled by the complaint process?

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



If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care
Are you unhappy with the quality of the care you've received (including care in the hospital)?

Respecting your privacy
Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our plan's Member Services has dealt with you?
- Do you feel you are being encouraged to leave our plan (disenroll from our plan)?

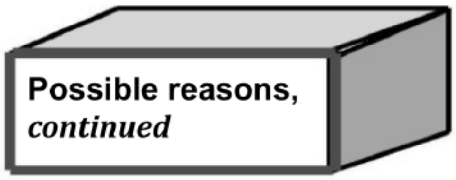
Cleanliness
Are you unhappy with the cleanliness or condition of a doctor's office, clinic, or hospital?

Waiting times
Are you having trouble getting an appointment, or waiting too long to get it?
Have you been kept waiting too long:

- By doctors or other health professionals?
- By Member Services or other staff at our plan?
- Examples include waiting too long on the phone, in the waiting room, or in the exam room.

Information you get from our plan

- Do you believe we haven't given you a notice that we're required to give?
- Do you think written information we have given you is hard to understand?



These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, *not* the complaint process. However, if you have already asked for a coverage decision or made an appeal, and you think that our plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked our plan to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we don't do that, you can make a complaint.

Chapter 7
Section 9.2

The formal name for "making a complaint" is "filing a grievance"

Legal terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Chapter 7
Section 9.3

Step-by-step: Making a complaint

Step 1 ➔ Contact us promptly – either by phone or in writing

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. [*Insert phone number, TTY/TDD, and hours of operation.]*
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:
  - *[Insert description of the procedures (including time frames) and instructions about what members need to do if they want to use the formal process for making a complaint. Describe expedited grievance time frames for grievances about decisions to not conduct expedited organization/coverage determinations or reconsiderations/redeterminations.]*
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 days after you had the problem you want to complain about.
- **If needed, you may ask for a "fast" complaint.** If you ask for a "fast" complaint, and we agree to give it to you, we will give you **an answer within 24 hours**. You can ask for a "fast" complaint if you think a slower response could harm your health or hurt your ability to function.

Legal terms

What this section calls a **"fast complaint"** is also called a **"fast grievance."**

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

- **The longest time we can take to answer a complaint is 30 days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know in writing. Our response will include our reasons for this answer.

Chapter 7 Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.

- **Or, you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

CHAPTER 8: Ending your membership in the plan

SECTION 1 Introduction

Chapter 8 Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in *[insert plan name]* 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 only certain times during the year, or certain situations, when you may end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

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

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Chapter 8 Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period (**also known as the "Annual Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens every year from November 15 to December 31.

- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare Advantage plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
    - Original Medicare *with* a separate Medicare prescription drug plan
    - – *or* –Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Chapter 8
Section 2.2

You can end your membership during the Medicare Advantage Open Enrollment Period, but your plan choices are more limited

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

- **When is the Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.

- **What type of plan can you switch to during the Medicare Advantage Open Enrollment Period?** During this time, you can make *one* change to your health plan coverage. However, you may *not* add or drop prescription drug coverage during this time. Since you are currently enrolled in a Medicare Advantage plan that does not include prescription drug coverage, this means that you can enroll in *either*:
    - Another Medicare Advantage plan that does not include prescription drug coverage
    - ***– or –***Original Medicare. (You cannot enroll in a separate prescription drug plan during the Medicare Advantage Open Enrollment Period.)

- **When will your membership end?** Your membership will end on the first day of the month after we get your request to change plans.

Chapter 8 Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of *[insert plan name]* may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** These are just examples, for the full list you can contact the plan, call 1-800-MEDICARE, or visit the Medicare website at www.Medicare.gov:

- If you have moved.
    - If you have Medicaid.
    - If you live in a facility, such as a nursing home.

    These are three common examples of Special Enrollment Periods. There are more Special Enrollment Periods for other situations. To find out more, contact member services or 1-800-MEDICARE for more information.

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
    - Another Medicare Advantage plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
    - Original Medicare *with* a separate Medicare prescription drug plan.
    - – *or* –Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Chapter 8 Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are on the cover of this booklet).

- You can find the information in the ***Medicare & You 2010*** handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from www.medicare.gov. Or, you can order a printed copy by calling Medicare at the number below.
- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week.

SECTION 3 How do you end your membership in our plan?

Chapter 8 **Section 3.1** You end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another health plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). One exception is when you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan.

In this situation, you must contact *[insert plan name]* Member Services and ask to be disenrolled from our plan.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare Advantage plan	• Enroll in the new Medicare Advantage plan. You will automatically be disenrolled from *[insert plan name]* when your new plan's coverage begins.
• Original Medicare *with* a	• Enroll in the new Medicare prescription

If you would like to switch from our plan to:	This is what you should do:
separate Medicare prescription drug plan.	drug plan. You will automatically be disenrolled from *[insert plan name]* when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan	• **Contact Member Services and ask to be disenrolled from the plan (phone numbers are on the cover of this booklet).** • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from *[insert plan name]* when your coverage in Original Medicare begins.

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

Chapter 8 **Section 4.1** Until your membership ends, you are still a member of our plan

If you leave *[insert plan name]*, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

- **If you are hospitalized on the day that your membership ends, you will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 *[Insert plan name]* can end your membership in the plan

Chapter 8 Section 5.1 When will we end your membership in the plan?

***[Insert plan name]* must end your membership in the plan if any of the following happen:**

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- [*SNPs insert:* If you no longer are *[insert SNP category]*.]
- If you move out of our service area for more than [*Plans without visitor/traveler benefits:* six months] [*Plans with visitor/traveler benefits:* [*insert number up to 12*] months].
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area.
    - [*Plans with visitor/traveler benefits, insert:* Chapter 3 and Chapter 4 give more information about getting care when you are away from the service area.]
    - [*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 *and* you were living outside of our service area before January 1999, you may continue your membership. However, if you move and your move is to another location that is outside of our service area, you will be disenrolled from our plan.]
- [*Omit if not applicable]* If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- [*Omit bullet and sub-bullet if not applicable]* If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
    - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- [*Omit bullet and sub-bullet if not applicable]* If you let someone else use your membership card to get medical care.
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

- *[Omit bullet and sub-bullet if not applicable]* If you do not pay the plan premiums for [*insert length of grace period*].
    - We must notify you in writing that you have *[insert length of grace period]* to pay the plan premium before we end your membership.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are on the cover of this booklet).

Chapter 8
Section 5.2

We cannot ask you to leave our plan for any reason related to your health

[Chronic care SNPs, delete this section.]

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Chapter 8
Section 5.3

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

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

CHAPTER 9: Legal notices

*[**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.]*

SECTION 1 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.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, 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.]*

CHAPTER 10: Definitions of important words

[Plans should 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.]

[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 Chapter 10 with a reference from the section where you use it: IPA, network, PHO, plan medical group, Point of Service.]

[Plans with a POS option: 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 or payment for services you already received. 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 an item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Benefit period – For [both our Plan and] Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. *[Plans that 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.

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.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Chapter 2 explains how to contact CMS.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physician's services, physical therapy, social or psychological services, and outpatient rehabilitation.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any

deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a service.

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 – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial care -- 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 drugs you receive before our plan begins to pay its share of your covered 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).

Durable medical equipment – Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

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.

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.

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.

Medically necessary – Drugs, 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**. 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).

[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 Original Medicare coverage. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

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

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

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 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."

[*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 – ("Traditional Medicare" or "Fee-for-service" Medicare) Original Medicare 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 booklet in Chapter 3.

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.)

Primary Care [*insert as appropriate:* Physician *OR* Provider] (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. Chapter 3 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 or certain drugs that may or may not be on our formulary. *[Plans may delete applicable sentences if it does not require prior*

authorization for any medical services.] Some in-network medical 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 Chapter 4.

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 Chapter 2 for information about how to contact the QIO in your state and Chapter 7 for information about making complaints to the QIO.

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

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.

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 – Urgently needed care is a non-emergency situation when a you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger. Because of the situation, it isn't reasonable for you to obtain medical care from a network provider.