Annual Notice of Change & Evidence of Coverage for Medicare Advantage Prescription Drug Plans

[Insert date]

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

Here are three 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 and prescription drugs. Please look through this document so you know what's in it, then keep it handy for reference.

3. We're also including a copy of *[insert plan name]* plan's **List of Covered Drugs (Formulary),** (**"Drug List"** for short) effective in January 2010.

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 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, including your prescription drug coverage. *[Plans that are changing the plan name or consolidating other plans into the plan in which the beneficiary is enrolled insert:* 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. Our phone numbers and address will remain the same.] *[Plans that are passively enrolling the beneficiary into another plan due to a consolidation or termination, insert:* As we have explained, if you do not choose another plan or 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. Our phone numbers and address will remain the same.*]*

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 changing the plan name or consolidating other plans into the plan in which the beneficiary is enrolled insert: 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. Our phone numbers and address will remain the same.] *[Plans that are passively enrolling the beneficiary into another plan due to a consolidation or termination, insert:* As we have explained, if you do not choose another plan or 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. Our phone numbers and address will remain the same.*]*

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 pay 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 services and prescription drugs. (We have included you 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 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].

There are programs to help people with limited resources pay for their prescription drugs

You might qualify to get help in paying for your drugs. There are [*insert as applicable:* one *OR* two] basic kinds of help:

- **"Extra Help" from Medicare.** This program is also called the "low-income subsidy" or LIS. People whose yearly income and resources are below certain limits can qualify for this help. See Section III of the new *Medicare & You 2010* Handbook or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- *[Plans without an SPAP in their state(s), should delete this bullet.]* **Help from your state's pharmaceutical assistance program.** Many states have State Pharmaceutical Assistance

Programs (SPAPs) that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules. Check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Chapter 2, Section 3 of your *Evidence of Coverage*).

What if you are currently getting help to pay for your drugs?

[Delete this section if this is your LIS ANOC.]

If you already get help paying for your drugs, **some of the information in this *Notice of Changes* is not correct for you**. Please call Member Services and ask for the *Notice of Changes* for people who get extra help paying for drugs.

Section 2. Changes to your monthly premium

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

Exception: If you are required to pay a late enrollment penalty (because you did not join a Medicare drug plan when you first became eligible), your monthly premium for 2010 will be *[insert 2010 premium amount] plus* the amount of your late enrollment penalty. For more information about this penalty, see Chapter 6 of your *Evidence of Coverage*.

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 2010 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 <u>what</u> <u>you</u> <u>pay</u>

[*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 it is 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]*	*[insert 2010 cost-sharing]*

	[for coinsurance amounts add: (you pay xx% of the total cost)]	*[for coinsurance amounts add: (you pay xx% of the total cost)]*

Section [X]. Part D Prescription Drugs: Changes to your benefits and what you pay

[*If there are no changes in benefits or in cost-sharing, replace remainder of Section 4 with:*

[Insert plan name] has a "*List of Covered Drugs (Formulary)*" – or "Drug List" for short. It tells which Part D prescription drugs are covered by the plan. (Chapter 5, Section 1.1 of your *Evidence of Coverage* explains about Part D drugs.)

The drugs included on our Drug List and the amount you will pay for covered drugs will be the same in 2010 as in 2009. However, we are allowed to make changes to the plan's Drug List from time to time throughout the year, with approval from Medicare.]

Changes to your benefits

[Insert plan name] has a "*List of Covered Drugs (Formulary)*" – or "Drug List" for short. It tells which Part D prescription drugs are covered by the plan. (Chapter 5, Section 1.1 of your *Evidence of Coverage* explains about Part D drugs.)

[*If there are no changes in benefits but changes in cost-sharing, replace text below with:* The drugs included on our Drug List will be exactly the same in 2010 as in 2009. However, there are some changes in what you will pay for these covered drugs. In addition, we are allowed to make changes to the plan's Drug List from time to time throughout the year, with approval from Medicare.]

We make changes to the plan's Drug List from time to time throughout the year. In addition, there are a number of changes to the Drug List that will take effect on January 1, 2010. Changes to the plan's Drug List have been approved by Medicare.

- **[***Insert if applicable:* **We have [*insert as applicable:* added some new drugs to the list and removed others *OR* added some new drugs to the list *OR* removed some drugs from the list]**. [*Insert if applicable:* We have added some new drugs that became available.] [*Insert if applicable:* We have replaced some brand-name drugs with new generic drugs.] [*Insert if applicable:* We have replaced some expensive drugs with less costly drugs that have been shown to work just as well or better.] [*Insert if applicable:* We have removed a few drugs due to safety concerns or because medical research has shown they are not effective.] *[Plans may describe other types of changes to the formulary here.]*

- **[***Insert if applicable:* **We have [*insert as applicable:* added some new restrictions to certain drugs, and reduced the restrictions on others *OR* added some new restrictions to certain drugs *OR* reduced the restrictions on some drugs].** *[Plans may edit the next two sentences to delete references to types of utilization management that they do not use.]* Restrictions can include a requirement to get plan approval in advance or to try a different drug first to see how well it works. Restrictions can also include limits on quantity of the drug.]

Please check to see if any of these changes to drug coverage affect the drugs you use.

- You can look for your drugs on the Drug List we sent with this *Notice of Change*. [*If including a complete formulary, insert:* If you can't find some of your drugs on this Drug List, you can call Member Services for help finding your drugs.]
- [*If including an abridged formulary, use the following language:* The Drug List we sent includes many of the drugs that we cover, but it does not include all of our covered drugs. If you can't find some of your drugs on this Drug List, you may find them on a complete Drug List, which includes all the drugs we cover. You can get the complete Drug List by calling Member Services or visiting our website ([*insert URL]*).]

Changes to <u>what</u> <u>you</u> <u>pay</u>

[*If there are no changes in cost-sharing, replace text and table below with:* The [*insert as applicable:* copayment *OR* coinsurance *OR* copayment and coinsurance] amount you pay for covered drugs will be exactly the same in 2010 as it is in 2009.]

[*Plans should edit or add to the information below to describe any changes in cost group structure or types of drugs in each cost group, as necessary.]*

The chart below summarizes changes to what you will pay as your share of the cost of covered prescription drugs. These changes affect Part D prescription drugs only.

- [*Plans without drug cost groups, replace this bullet with:* Medicare allows us to **change what you pay for a drug** only once a year. The changes shown below will take effect on January 1, 2010, and stay the same for the entire plan year.] Every drug on the plan's Drug List is in one of *[insert number of cost groups]* Cost Groups. Medicare allows us to **change what you pay for a drug in each Cost Group** only once a year. The changes shown below will take effect on January 1, 2010, and stay the same for the entire plan year.
- [*Plans without drug cost groups and plans with no change in cost group assignment, delete this bullet.]* Besides the changes to [*insert as applicable:* copayment *OR* coinsurance *OR* copayment and coinsurance] you see below, there is another change that could affect what you pay for your drugs next year. **We have moved some of the drugs on the Drug List to a different Cost Group**. Some drugs will be in a lower Cost Group, others will be in a higher Cost Group. To see if any of your drugs have been moved to a different Cost Group, look them up on the Drug List.

[Plans should list all changes to cost-sharing in the table below. Plans may add or delete rows as necessary. Plans without drug cost groups may revise the table as appropriate.]

	2009 (this year)	**2010 (**next year)
Drugs in Cost Group *[x]* (*[insert short description of cost group (e.g., generic drugs)]*) For a one-month (30 day) supply of a drug in Cost Group *[x]* that is filled at a network pharmacy	*[insert 2009 cost-sharing:* *For copayments:* You pay $xx per prescription. *For coinsurance:* You pay xx% of the total cost.]	*[insert 2010 cost-sharing:* *For copayments:* You pay $xx per prescription. *For coinsurance:* You pay xx% of the total cost.]
Drugs in Cost Group *[x]* (*[insert short description of cost group (e.g., generic drugs)]*) For a one-month (30 day) supply of a drug in Cost Group *[x]* that is filled at a network pharmacy	*[insert 2009 cost-sharing:* *For copayments:* You pay $xx per prescription. *For coinsurance:* You pay xx% of the total cost.]	*[insert 2010 cost-sharing:* *For copayments:* You pay $xx per prescription. *For coinsurance:* You pay xx% of the total cost.]

What if changes for 2010 affect drugs you are taking now?

[Delete if plan is not removing any drugs from formulary:] What if a drug you are taking now is not on the Drug List for 2010? *[Delete if plan is not changing the cost group assignment for any drugs on the formulary or if the plan does not use cost groups:]* What if it has been moved to a higher Cost Group? *[Delete if plan is not adding restrictions to any drug on the formulary:]* What if a new restriction has been added to the coverage for this drug? If you are in any of these situations, here's what you can do:

- *[Plans may omit this bullet if they allow current members to request formulary exceptions in advance for the following year:]* In some situations, the plan will cover a **one-time, temporary supply** of your drug when your current supply runs out. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. Chapter 5, Section 6.2 explains when you can get a temporary supply and how to ask for one.

[Plans may omit this sentence if they allow current members to request formulary exceptions in advance for the following year:] Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.
- **You and your doctor can ask the plan to make an exception for you** and cover the drug. *[Plans may omit the following sentence if they allow current members to receive a temporary supply instead:]* You can ask for an exception in advance for next year and we will give you an answer to your request before the change takes effect. To learn what you must do to ask for an exception, see the *Evidence of Coverage* that was included in the mailing with this *Notice of Changes.* Look for Chapter 9 (*What to do if you have a problem or complaint*).

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

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]. 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 [*insert as applicable:* Medicare Advantage *OR* Medicare prescription drug] 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 with Part D prescription drug coverage or switch to the Original Medicare Plan plus a Medicare Prescription Drug Plan. For more information about your choices during the January 1 through March 31 open enrollment period, please see Chapter 10, 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, those who get Extra Help paying for their drugs, or those who move out of the geographic service area, can make changes at other times. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

How do you make a change?

See Chapter 10 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 employer retiree group before you switch to another way of getting medical care.
- *[Plans in state(s) without an SPAP, delete this bullet.]* **Are you getting help with paying for your drugs from a State Pharmaceutical Assistance Program (SPAP)?** If you are, please check with this program before switching to another prescription drug plan. The phone number for your State Pharmaceutical Assistance Program is listed in Chapter 2, Section 7 of the *Evidence of Coverage.*

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* and of the *List of Covered Drugs (Formulary)*.

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 (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, including your prescription drugs
- 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.**

Explain key terms used in this booklet.

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

SECTION 1. Introduction

SECTION 2. What makes you eligible to be a plan member?

SECTION 3. What other materials will you get from us?

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

SECTION 5. Please keep your plan membership record up to date

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 and prescription drugs 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 and your prescription drug coverage through our plan, *[insert plan name]*.
- There are different types of Medicare Advantage Plans. *[Insert plan name]* is a Medicare Advantage HMO Plan (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 and the prescription drugs 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, the *List of Covered Drugs (Formulary)*, 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 and 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 a 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 [*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 live in this service area. To stay a member of our plan, you 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 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 care and drugs

[Plans that use separate membership cards for health and drug coverage should edit the following section to reflect the use of multiple cards.]

[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 and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:

[Insert picture of front and back of member ID 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. 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, while you are a member of our plan you [*insert as appropriate:* must use *OR* may be required to use] network providers to get your medical care and services. 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 information describing available formats for the provider directory (e.g., hard copy, disk), the information available in the directory, and/or hot to access the directory via the website or through Member Services.*]

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

Chapter 1
Section 3.3

The *Pharmacy Directory*: your guide to pharmacies in our network

[Plans with combined provider and pharmacy directories may edit the provider and pharmacy directory paragraphs to describe the combined document.]

What are "network pharmacies"?

Our *Pharmacy Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. *[Plans may add detail describing additional information included in the pharmacy directory.]* This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

We will send you a complete *Pharmacy Directory* **at least once every three years**. Every year that you don't get a new *Pharmacy Directory*, we'll send you a booklet that shows changes to the directory.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services (phone numbers are on the front cover). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at [*insert URL*]. *[Plans may add detail describing additional information about network pharmacies available from Member Services or on the website.]*

Chapter 1
Section 3.4

The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by *[insert plan name]*. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the *[insert plan name]* Drug List.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website ([*insert URL*]) or call Member Services (phone numbers are on the front cover of this booklet).

Chapter 1
Section 3.5

Monthly reports with a summary of payments made for your prescription drugs

When you use your prescription drug benefits, we will send a report to help you understand and keep track of payments for your prescription drugs. This summary report is called the *Explanation of Benefits*.

The *Explanation of Benefits* tells you the total amount you have spent on your prescription drugs and the total amount we have paid for each of your prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

At any time during the year, you can also ask us to give you an *Explanation of Benefits* summary. To get a copy, please contact Member Services.

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 <u>less</u> than [*insert monthly premium amount*]

[*Plans with no monthly premium: Omit this subsection.*]

There are programs to help people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about these programs. If you qualify for one of these programs, enrolling in the program might make your monthly plan premium lower than [*insert monthly premium amount*].

[Delete if this is your LIS EOC:] If you are *already enrolled* and getting help from one of these programs, **some of the payment information in this *Evidence of Coverage* may not apply to you**. Please call Member Services to get the correct information about what you pay.

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

[Insert if applicable: 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.]

Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't keep their coverage. For these members, the plan's monthly premium will be higher. It will be [*insert monthly premium amount]* plus the amount of their late enrollment penalty.

If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section 9 explains the late enrollment penalty.

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 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). Checks should be made payable to the Plan and sent directly to the Plan, not CMS or HHS. 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 payment

You can have the plan premium taken out of your monthly Social Security payment. 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 we end your membership, 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.]

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.

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.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year. If a member qualifies for Extra Help with their prescription drug costs, the Extra Help program will pay part of the member's monthly plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less toward their monthly premium. And a member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about Extra Help in Chapter 2, Section 7.

What if you believe you have qualified for "Extra Help"

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

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

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, pharmacists, 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 and drugs 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 and Part D 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 9 (*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 9 (*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 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

[Insert plan name] **Coverage Decisions for Part D Prescription Drugs**	
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 coverage 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 coverage determinations, also include that number here.]*
FAX	*[Optional: insert fax number] [**Note**: If you have a different fax number for accepting expedited coverage determinations, also include that number here.]*
WRITE	*[Insert address] [**Note**: If you have a different address for accepting expedited coverage determinations, also include that address here.]*

For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

How to contact us when you are making an appeal about your Part D prescription drugs

[Insert plan name] **Appeals for Part D Prescription Drugs**	
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 address here.]*

For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*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 Part D prescription drugs

[Insert plan name] **Complaints about Part D prescription drugs**	
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 address here.]*

For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*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 or a drug 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 7 (*Asking the plan to pay its share of a bill you have received for medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

[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	www.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 outpatient rehabilitation 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

The Social Security Administration 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. The Social Security Administration 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 ET to 7:00 pm ET, 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 ET to 7:00 pm ET, Monday through Friday.
WEBSITE	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 Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

If you think you may qualify for Extra Help, call Social Security (see Section 5 of this chapter for contact information) to apply for the program. You may also be able to apply at your State Medical Assistance or Medicaid Office (see Section 6 of this chapter for contact information). After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

State Pharmaceutical Assistance Programs

[Plans without an SPAP in their state(s), should delete this section.]

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

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

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

In [*insert state name*], the [*insert state-specific SPAP name*] is a state organization that provides limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs.

[Insert state-specific SPAP 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 8 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	www.rrb.gov

SECTION 9 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 information about this, see Section 2.1 in this chapter).
  - In most situations, your PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information 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 information about this, see Section 2.3 of this chapter).
- *[Plans with a POS option may edit the network provider bullets as necessary.]* **You generally must receive your care from a network provider** (for more information 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:*
  - The plan covers emergency care or urgently needed care that you get from a non-network provider. For more information about this, and to see what emergency or urgently needed care means, 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 happens when a provider leaves the network. (Instructing members to call member services for instructions is not describing the process.) Include detailed information on plan notification of members. Typical offers of replacement specialists and phone numbers to call if urgent situations arise.]*

[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. 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 reasonably 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 information 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 information 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. *[Plans with overseas care covered as a supplemental benefit: modify this section.]*

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 (*Asking the plan to pay its share of a bill you have received for medical services or drugs*) 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, are covered under Medicare, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out of network where not authorized.

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.

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 Original Medicare's 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, our plan will instead provide coverage for care in a 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 your condition would ordinarily meet the conditions for coverage of services 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 you 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

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 preventive 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.*
- *SNPs may modify the language, as applicable, to address Medicaid benefits and cost-sharing for its dual eligible population.]*

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

[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
the first pint used. *[Modify as necessary if the plan begins coverage with an earlier pint.]* • 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 treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative	*[List copays / coinsurance]*

Services that are covered for you	**What you must pay** when you get these services
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:* you must return to a network hospital in

Services that are covered for you		**What you must pay** when you get these services
		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.]*
Outpatient rehabilitation 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: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.		*[List copays / coinsurance]*
Prosthetic devices and related supplies Devices (other than dental) that replace a body part or function. These include colostomy bags and supplies directly related to colostomy care,		*[List copays / coinsurance]*

Services that are covered for you		**What you must pay** when you get these services
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.		
Diabetes self-monitoring, training, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Self-management training is covered under certain conditions • For persons at risk of diabetes: Fasting plasma glucose tests. *[Insert frequency]* *[Also list any additional benefits offered.]*		*[List 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: • 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		*[List copays / coinsurance]*

Services that are covered for you	**What you must pay** when you get these services
• 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	
"Welcome to Medicare" exam Welcome to Medicare exam (covered during the first 12 months that the enrollee has Medicare Part B). *[Also list any additional benefits offered.]*	The reimbursement for this benefit does not include reimbursement for EKGs, clinical laboratory tests, as well as screening and other preventative

Services that are covered for you	**What you must pay** when you get these services
	services currently covered under Medicare Part B.
[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]*
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: • 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	*[List copays / coinsurance]*

Services that are covered for you		**What you must pay** when you get these services
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 *[Also list any additional benefits offered.]*		*[List copays / coinsurance]*
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months:		*[List copays / coinsurance]*

Services that are covered for you		**What you must pay** when you get these services
• Digital rectal exam • Prostate Specific Antigen (PSA) test *[Also list any additional benefits offered.]*		
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 6 months that they have Medicare Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Doesn't include lab tests.]		*[List copays / coinsurance]*
Other Services		
Dialysis (kidney) Covered services include: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Section 2) • Inpatient dialysis treatments (if you are admitted to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)		*[List copays / coinsurance]*

Services that are covered for you	**What you must pay** when you get these services
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	
[For all additional benefits information, plans should include only applicable rows.] **Dental services**	*[List copays / coinsurance]*

Services that are covered for you		**What you must pay** when you get these services
[List any additional benefits offered, such as routine dental care.]		
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 Original Medicare's 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: Using the plan's coverage for your Part D prescription drugs

SECTION 7. What if your coverage changes for one of your drugs?

SECTION 8. What types of drugs are *not* covered by the plan?

SECTION 9. Show your plan membership card when you fill a prescription

SECTION 10. Part D drug coverage in special situations

SECTION 11. Programs on drug safety and managing medications

[Delete this box if this is your LIS EOC.]

Did you know there are programs to help people pay for their drugs?

[*Insert as appropriate, depending on whether SPAPs are discussed in Chapter 2:* There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and state pharmaceutical assistance programs. *OR* The "Extra Help" program helps people with limited resources pay for their drugs.] For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* may not apply to you.** Please call Member Services and ask for the *Evidence of Coverage* for people who get extra help paying for drugs. Phone numbers for Member Services are on the front cover.

SECTION 1 Introduction

Chapter 5
Section 1.1

This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, *[insert plan name]* also covers some drugs under the plan's medical benefits:

- The plan covers **drugs you are given during covered stays in the hospital or in a skilled nursing facility**. Chapter 4 (*Medical benefits chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.

- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, **certain** drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Medical benefits chart, what is covered and what you pay*) tells about the benefits and costs for Part B drugs.

The two types of drugs described above are covered by the plan's medical benefits. The rest of your prescription drugs are covered under the plan's Part D benefits. **This chapter explains rules for using your coverage for Part D drugs.** The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

Chapter 5 **Section 1.2** Basic rules for the plan's Part D drug coverage

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

- [*Omit if not applicable:* You must have a network provider write your prescription. (For more information, see Section 2, *Your prescriptions should be written by a network provider*.)]
- You must use a network pharmacy to fill your prescription. (See Section 3, *Fill your prescriptions at a network pharmacy*.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 4, *Your drugs need to be on the plan's drug list*.)
- Your drug must be considered "medically necessary," meaning reasonable and necessary for treatment of your injury or illness. It also needs to be an accepted treatment for your medical condition.

SECTION 2 Your prescriptions should be written by a network provider

[Plans should omit this section if not applicable.]

Chapter 5 **Section 2.1** In most cases, your prescription must be from a network provider

You need to get your prescription (as well as your other care) from a provider in the plan's provider network. This person would often be your primary care provider (your PCP). It could also be another professional in our provider network if your PCP has referred you for care.

To find network providers, look in the *Provider Directory*.

The plan will cover prescriptions from providers who are not in the plan's network only in a few special circumstances. These include:

- Prescriptions you get in connection with emergency care.
- Prescriptions you get in connection with urgently needed care when network providers are not available.
- Dialysis you get when you are traveling outside of the plan's service area.

Other than these circumstances, you must have approval in advance ("prior authorization") from the plan to get coverage of a prescription from an out-of-network provider.

If you pay "out-of-pocket" for a prescription written by an out-of-network provider and you think we should cover this expense, please contact Member Services or send the bill to us for payment. Chapter 7, Section 2.1 tells how to ask us to pay our share of the cost.

SECTION 3 Fill your prescription at a network pharmacy or through the plan's mail order service

Chapter 5 Section 3.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies.

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered by the plan.

[Include if plan has both preferred and non-preferred pharmacies in their networks: Preferred pharmacies are pharmacies in our network where the plan has negotiated lower cost-sharing for members for covered drugs than at [*insert either:* non-preferred pharmacies *OR* other network pharmacies.] However, you will still have access to lower drug prices at [*insert either:* non-preferred pharmacies *OR* these other network pharmacies] than at out-of-network pharmacies. You may go to either of these types of network pharmacies to receive your covered prescription drugs. [*Describe restrictions imposed on members that use non-preferred pharmacies.*]]

Chapter 5
Section 3.2

Finding network pharmacies

How do you find a network pharmacy in your area?

You can look in your *Pharmacy Directory*, visit our website ([*insert URL*]), or call Member Services (phone numbers are on the cover). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask to [*insert if applicable:* either have a new prescription written by a doctor or] to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are on the cover) or use the *Pharmacy Directory*.

What if you need a specialty pharmacy?

Sometimes prescriptions must be filled at a specialty pharmacy. Specialty pharmacies include:

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

To locate a specialty pharmacy, look in your *Pharmacy Directory* or call Member Services.

Chapter 5
Section 3.3

Using the plan's mail-order services

[Omit if the plan does not offer mail-order services.]

[Include the following information only if your mail-order service is limited to a subset of all formulary drugs, adapting terminology as needed: For certain kinds of drugs, you can use the plan's network mail-order services. These drugs are marked as [*insert either:* **"maintenance"** *OR* "**mail order"**] **drugs** on our plan's Drug List. ([*Insert either:* Maintenance *OR* Mail order] drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)]

Our plan's mail-order service requires you to order [*insert either:* ***at least*** **a [XX]-day supply of the drug and** ***no more than*** **a [XX]-day supply** *OR* **up to a [XX] day supply**].

To get [*insert if applicable:* order forms and] information about filling your prescriptions by mail [*insert instructions*]. If you use a mail order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than [XX] days. [*Insert plan's process for members to get a prescription if the mail-order is delayed.*]

Chapter 5
Section 3.4

How can you get a longer-term supply of drugs?

When you get a longer-term supply of drugs, your cost sharing may be lower. The plan offers [*insert as appropriate:* a way *OR* two ways] to get a longer-term supply of [*insert either:* "maintenance" *OR* "mail order"] drugs on our plan's Drug List. ([*Insert either:* Maintenance *OR* Mail order] drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a longer-term supply of [*insert either:* maintenance *OR* mail order] drugs. Some of these retail pharmacies [*insert if applicable:* may] agree to accept [*insert as appropriate:* a lower *OR* the mail-order] cost-sharing amount for a longer-term supply of [*insert either:* maintenance *OR* mail order] drugs. [*Insert if applicable:* Other retail pharmacies may not agree to accept the [*insert as appropriate:* lower *OR* mail-order] cost-sharing amounts for an extended supply of [*insert either:* maintenance *OR* mail order] drugs. In this case you will be responsible for the difference in price.] Your *Pharmacy Directory* tells you which pharmacies in our network can give you a longer-term supply of [*insert either:* maintenance *OR* mail order] drugs. You can also call Member Services for more information.

2. *[Delete if plan does not offer mail order service.]* For certain kinds of drugs, you can use the plan's network **mail-order services.** These drugs are marked as [*insert either:* maintenance *OR* mail order] drugs on our plan's Drug List. Our plan's mail-order service requires you to order [*insert either: at least* a [XX]-day supply of the drug and *no more than* a [XX]-day supply *OR* up to a [XX] day supply]. See Section 3.3 for more information about using our mail-order services.

Chapter 5
Section 3.5

When can you use a pharmacy that is not in the plan's network?

Your prescription might be covered in certain situations

[*Insert if applicable:* We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.] Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

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

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 4 **Your drugs need to be on the plan's "Drug List"**

Chapter 5
Section 4.1

The "Drug List" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary).*" In this *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is medically necessary, meaning reasonable and necessary for treatment of your injury or illness.

The Drug List includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. It works just as well as the brand-name drug, but it costs less. There are generic drug substitutes available for many brand-name drugs.

What is *not* on the Drug list?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 8.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.

Chapter 5
Section 4.2

There are [*insert number of cost groups*] "Costs Groups" for drugs on the Drug List

[Plans that do not use drug cost groups should omit this section.]

Every drug on the plan's Drug List is in one of [*insert number of cost groups*] Cost Groups. In general, the higher the Cost Group number, the higher your cost for the drug:

- *[Plans should briefly describe each cost group (e.g., Cost Group 1 includes generic drugs). Indicate which is the lowest cost group and which is the highest cost group.]*

To find out which Cost Group your drug is in, look it up in the plan's *Drug List*.

The amount you pay for drugs in each Cost Group is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Chapter 5
Section 4.3

How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website ([*insert URL*]). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Member Services are on the front cover.

SECTION 5 There are restrictions on coverage for some drugs

Chapter 5
Section 5.1

Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you get a drug that works for your medical condition and is safe. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your doctor to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

Chapter 5
Section 5.2

What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

[Plans should include only the forms of utilization management used by the plan:]

Using generic drugs whenever you can

A "generic" drug works the same as a brand-name drug, but usually costs less. **When a generic version of a brand-name drug is available, our network pharmacies must provide you the generic version.** However, if your doctor has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your doctor need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" Sometimes plan approval is required so we can be sure that your drug is covered by Medicare rules. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try safer or more effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**Step Therapy.**"

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Chapter 5
Section 5.3

Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are on the front cover) or check our website ([*insert URL*]).

SECTION 6 What if one of your drugs is not covered in the way you'd like it to be covered?

Chapter 5 Section 6.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your doctor think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 5, some of the drugs covered by the plan have extra rules to restrict their use. For example, *[delete if plan does not have step therapy:* you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you.] *[Delete if plan does not have quantity limits:* Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.]
- **[*Omit if plan does not use drug cost groups:* What if the drug is covered, but it is in a Cost Group that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of *[insert number of cost groups]* different Cost Groups. How much you pay for your prescription depends in part on which Cost Group your drug is in.]

There are things you can do if your drug is not covered in the way that you'd like it to be covered. [*Delete if plan does not use drug cost groups:* Your options depend on what type of problem you have:]

- If your drug is not on the Drug List or if your drug is restricted, go to Section 6.2 to learn what you can do.
- [*Omit if plan does not use drug cost groups]* If your drug is in a Cost Group that makes your cost more expensive than you think it should be, go to Section 6.3 to learn what you can do.

Chapter 5
Section 6.2

What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of their drug (only members in certain situations can get a temporary supply).
- You can change to another drug.
- You can file an exception and ask the plan to cover the drug in the way you would like it to be covered.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your doctor about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **not on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 5 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- *[Plans may omit this scenario if they allow current members to request formulary exceptions in advance for the following year:]* **For those members who were in the plan last year and aren't in a long-term care facility:**

  We will cover a temporary supply of your drug **one time only during the first *[insert time period (must be at least 90 days)]* of the calendar year**. This temporary supply will be for a maximum of [*insert supply limit (must be at least a 30-day supply)*], or less if your prescription is written for fewer days.

- **For those members who are new to the plan and aren't in a long-term care facility:**

  We will cover a temporary supply of your drug **one time only during the first *[insert time period (must be at least 90 days)]* of your membership** in the plan. This temporary supply will be for a maximum of [*insert supply limit (must be at least a 30-day supply)*], or less if your prescription is written for fewer days.

- **For those who are new members, and are residents in a long-term-care facility:**

  We will cover a temporary supply of your drug **during the first *[insert time period (must be at least 90 days)]* of your membership** in the plan. The first supply will be for a maximum of [*insert supply limit (must be at least a 31-day supply)*], or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first [*insert time period (must be at least 90 days)]* in the plan.

- **For those who have been a member of the plan for more than *[insert time period (must be at least 90 days)]* and are a resident of a long-term care facility:**

  We will cover one [*insert supply limit (must be at least a 31-day supply)*] supply, or less if your prescription is written for fewer days.

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

To ask for a temporary supply, call Member Services (phone numbers are on the front cover.)

During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

You can change to another drug

Start by talking with your doctor. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your doctor or other prescriber can help you request an exception to the rule.

For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

[Plans that allow current members to receive a temporary supply instead, may omit the following paragraph:] If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage

for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

If you and your doctor or other prescriber want to ask for an exception, Chapter 9, Section 6.2 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Chapter 5 Section 6.3 What can you do if your drug is in a Cost Group you think is too high?

[Plans that do not use drug cost groups may omit this section.]

If your drug is a Cost Group you think is too high, here are things you can do:

You can change to another drug

Start by talking with your doctor. Perhaps there is a different drug in a lower Cost Group that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor can ask the plan to make an exception in the Cost Group for the drug so that you pay less for the drug. If your doctor or other provider says that you have medical reasons that justify asking us for an exception, your doctor can help you request an exception to the rule.

If you and your doctor want to ask for an exception, Chapter 9, Section 6.2 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 7 What if your coverage changes for one of your drugs?

Chapter 5 Section 7.1 The Drug List can change during the year

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

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **[***Insert if applicable:* **Move a drug to a higher or lower Cost Group**.]
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 5 in this chapter).
- **Replace a brand-name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

Chapter 5
Section 7.2

What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your doctor will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- [*Plans that do not use cost groups may omit:* If we move your drug into a higher Cost Group.]
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand-name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
    - During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.
    - Or you and your doctor or other prescriber can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
    - Your doctor will also know about this change, and can work with you to find another drug for your condition.

SECTION 8 What types of drugs are *not* covered by the plan?

Chapter 5 **Section 8.1** Types of drugs we do not cover

[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 of prescription drugs are "excluded." Excluded means that the plan doesn't cover these types of drugs because the law doesn't allow any Medicare drug plan to cover them.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section (unless our plan covers certain excluded drugs under supplemental prescription drug coverage). The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and 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 drug, go to Chapter 9, Section 6.5 in this booklet.)

Here are two general rules about drugs that Medicare drug plans don't cover:

- Our plan's coverage cannot cover a drug purchased outside the United States and its territories.
- Only in certain situations will our Plan cover what are called "off-label" use of a prescription drug. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for off-label use is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans (although they are allowed to be covered through supplemental drug benefits):

- [*Insert if applicable:* Generally, our plan may provide non-prescription drugs (also called over-the-counter drugs) in certain situations. Call Member Services for more information.]
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

[*Insert if applicable:* We offer additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan. [*Insert details about the excluded drugs your plan does cover, including whether you place any limits on that coverage.]* The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic

Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this booklet.)]

[*Insert if plan offers coverage for any drugs excluded under Part D:* In addition, if you are **receiving extra help from Medicare** to pay for your prescriptions, the extra help will not pay for the drugs not normally covered. (Please refer to your formulary or call Member Services for more information.) However, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.]

[Insert if plan does not offer coverage for any drugs excluded under Part D: **If you receive extra help paying for your drugs**, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.]

SECTION 9 Show your plan membership card when you fill a prescription

Chapter 5 **Section 9.1** Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Chapter 5 **Section 9.2** What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 10 Part D drug coverage in special situations

Chapter 5 Section 10.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can leave this plan and join a new Medicare Advantage plan or Original Medicare. (Chapter 10, *Ending your membership in the plan*, tells you can leave our plan and join a different Medicare plan.)

Chapter 5 Section 10.2 What if you're a resident in a long-term care facility?

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

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

What if you're a resident in a long-term care facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first [*insert time period (must be at least 90 days)]* of your membership. The first supply will be for a maximum of [*insert supply limit (must be at least a 31-day supply)*], or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first [*insert time period (must be at least 90 days)]* in the plan.

If you have been a member of the plan for more than [*insert time period (must be at least 90 days)]* and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one [*insert supply limit (must be at least a 31-day supply)*] supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your doctor want to ask for an exception, Chapter 9, Section 6.2 tells what to do.

Chapter 5
Section 10.3

What if you're also getting drug coverage from an employer or retiree group plan?

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

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice by November 15 that tells if your prescription drug coverage will be "creditable" for the next year, and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that it has drug coverage that pays, on average, at least as much as Medicare's standard drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage so that you do not have to pay a late enrollment penalty. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from your employer or retiree plan's benefits administrator or the employer or union. See Chapter 6, Section 10.3 for more information about the late enrollment penalty.

SECTION 11 Programs on drug safety and managing medications

Chapter 5 Section 11.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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

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

If we see a possible problem in your use of medications, we will work with your doctor to correct the problem.

Chapter 5 Section 11.2 Programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will send you information that tells you what you need to do to join it. If we do contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

CHAPTER 6: What you pay for your Part D prescription drugs

[Delete this box if this is your LIS EOC.]

Did you know there are programs to help people pay for their drugs?

[*Insert as appropriate, depending on whether SPAPs are discussed in Chapter 2:* There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and state pharmaceutical assistance programs. *OR* The "Extra Help" program helps people with limited resources pay for their drugs.] For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* may not apply to you.** Please call Member Services and ask for the *Evidence of Coverage* for people who get extra help paying for drugs. Phone numbers for Member Services are on the front cover.

SECTION 1 Introduction

Chapter 6
Section 1.1

Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, some drugs are covered under Original Medicare or are excluded by law. Some excluded drugs may be covered by our plan if the member purchases supplemental drug coverage.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you.
  - [*Plans that do not use cost groups, omit]* It also tells which of the [*insert number of cost groups*] "Cost Groups" the drug is in and whether there are any restrictions on your coverage for the drug.

  - If you need a copy of the Drug List, call Member Services (phone numbers are on the cover of this booklet). You can also find the Drug List on our website at [*insert URL*]. The Drug List on the website is always the most current.

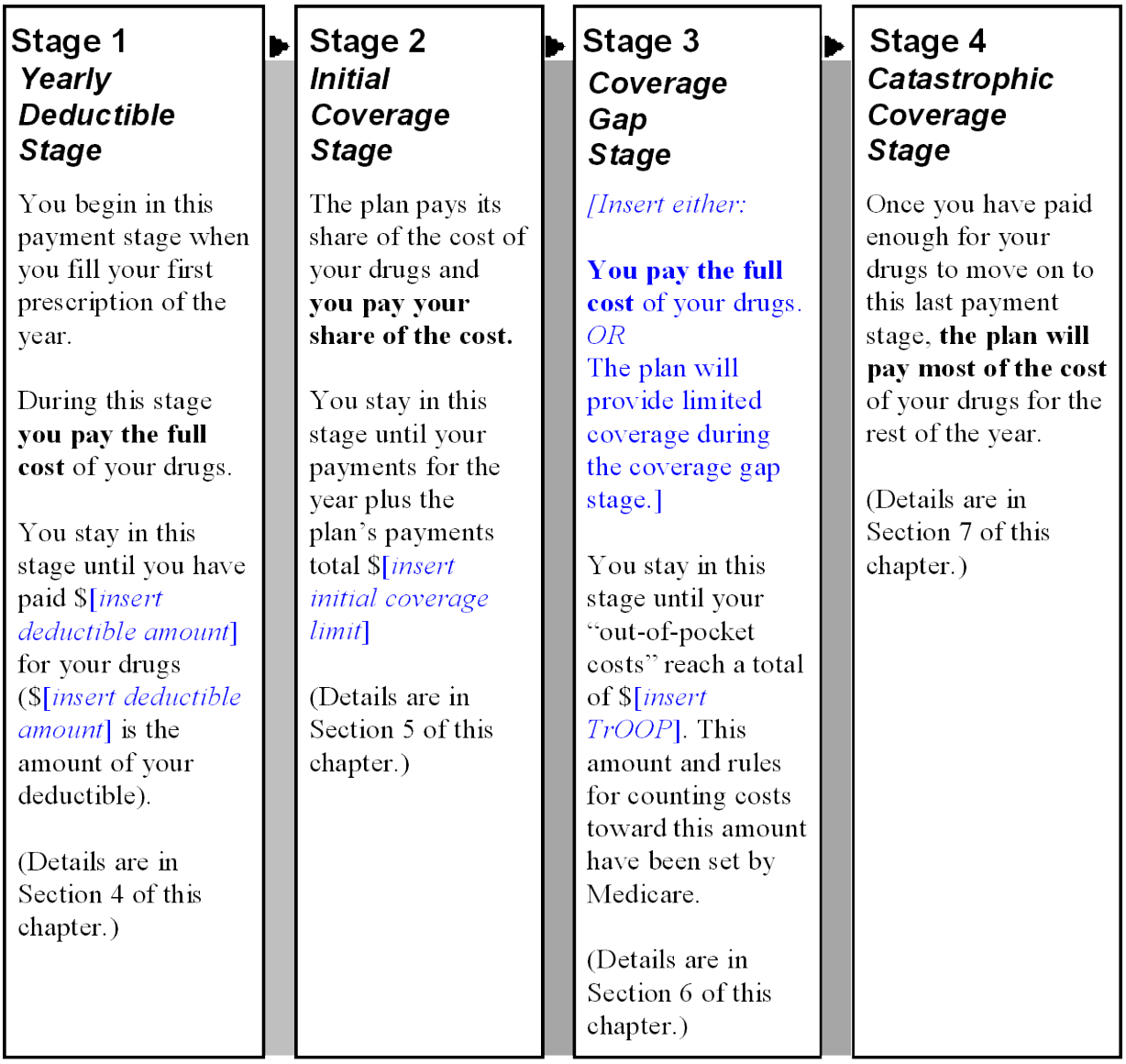
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan's *Pharmacy Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network and it tells how you can use the plan's mail order service to get certain types of drugs. It also explains how you can get a longer-term supply of a drug (such as filling a prescription for a three month's supply).

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Chapter 6 Section 2.1 What are the [*insert number of stages*] drug payment stages?

As shown in the table below, there are [*insert number of stages*] "drug payment stages" for your prescription drug coverage. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Despite your drug payment stage, you must pay your premium every month.

[Plans with no deductible should revise the chart as needed to describe their drug coverage stages.]



As shown in this summary of the [*insert number of stages*] payment stages, whether you move on to the next payment stage depends on how much you spend for your drugs while you are in each stage.

SECTION 3 We send you reports that tell about payments for your drugs and which payment stage you are in

Chapter 6 Section 3.1 We send you a monthly report called the "Explanation of Benefits"

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you pay yourself. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket plus the amount paid by the plan.

At the end of every month when you have had one or more prescriptions filled, we prepare a written report called the *Explanation of Benefits* (it is sometimes called the "EOB.") We mail a copy of this report to you. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the month. It shows the total drug costs, what the plan paid, and what you and others paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Chapter 6 Section 3.2 Help us keep our information about your drug payments up to date

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to

pay our share of the cost. For instructions on how to do this, go to Chapter 7 of this booklet.) Here are some types of situations when you may want to gives us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
- When you purchase a drug at a price that is better than you can get under our plan.
- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug.

- **Check the written report we send you.** When you receive an *Explanation of Benefits* in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are on the cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Yearly Deductible Stage, you pay the full cost of your drugs

[Plans with no deductible: Omit Section 4.]

Chapter 6 **Section 4.1** You stay in the Yearly Deductible Stage until you have paid $[*insert deductible amount*] for your drugs

The Yearly Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. [*Plans with a deductible for all drug types/cost groups, insert:* When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount, which is $[*insert deductible amount*] for 2010.] [*Plans with a deductible on only a subset of drugs, insert:* You will pay a yearly deductible of $[*insert deductible amount*] on [*insert applicable drug cost groups*] drugs. **You must pay the full cost of your [*insert applicable drug cost groups*] drugs** until you reach the plan's deductible amount For all other drugs you will not have to pay any deductible and will start receiving coverage immediately.]

- Your **"full cost"** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.

- The **"deductible"** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid $[*insert deductible amount*] for your drugs, you leave the Yearly Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Chapter 6 Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Period, the plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has [*insert number of cost groups*] Cost Groups

[Plans that do not use drug cost groups should omit this section.]

Every drug on the plan's Drug List is in one of [*insert number of cost groups*] Cost Groups. In general, the higher the Cost Group number, the higher your cost for the drug:

- *[Plans should briefly describe each cost group (e.g., Cost Group 1 includes generic drugs). Indicate which is the lowest cost group and which is the highest cost group.]*

To find out which Cost Group your drug is in, look it up in the plan's *Drug List*.

Your pharmacy choices

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

- *[Pharmacies with preferred and non-preferred pharmacies, delete this bullet and use next two bullets instead:]* A retail pharmacy that is in our plan's network
- *[Pharmacies with preferred and non-preferred pharmacies, insert:* A preferred pharmacy that is in our plan's network]
- *[Pharmacies with preferred and non-preferred pharmacies, insert either:* A non-preferred network pharmacy *OR* An another network pharmacy]
- A pharmacy that is not in the plan's network

- *[Plans without mail-order service, delete this bullet:]* The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan's *Pharmacy Directory*.

Chapter 6
Section 5.2

A table that shows your costs for a 30-day supply of a drug

[*Plans using only copayments or only coinsurance should edit this paragraph to reflect the plan's cost-sharing:]* During the Initial Coverage Period, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

[*Plans that do not use drug cost groups, omit:]* As shown in the table below, the amount of the copayment or coinsurance depends on which Cost Group your drug is in.

[If plan has any preferred pharmacies, the chart must be modified to reflect the appropriate member cost-sharing for preferred and non-preferred pharmacies. The plan may also add or remove cost groups as necessary.]

[If plan operates nationally or in multiple service areas, the chart may be modified to allow the option of indicating – either within the chart, or by reference to a separate chart – any variance in the cost-sharing levels for certain cost groups for plans in different service areas.] [Insert if applicable: The chart lists information for more than one of our plans. The name of the plan you are in is listed on the front page of this booklet. If you aren't sure which plan you are in or if you have any questions, call Member Services.*]*

Your share of the cost when you get a 30-day supply (or less) of a covered Part D prescription drug from:

	Network pharmacy	**The plan's mail-order service**	**Network long-term care pharmacy**	**Out-of-network Pharmacy (coverage is limited to certain situations, see Chapter 5 for details)**
Cost Group 1 ([*insert description, e.g., "generic drugs"*])	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*
Cost Group 2 ([*insert description*])	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*
Cost Group 3 ([*insert description*])	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*
Cost Group 4 ([*insert description*])	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*

Chapter 6
Section 5.3

A table that shows your costs for a longer-term [*insert number of days*] supply of a drug

For some drugs, you can get a longer-term supply (also called an "extended supply") when you fill your prescription. This can be up to a *[insert number of days]* supply. (For details on where and how to get a longer-term supply of a drug, see Chapter 5.)

The table below shows what you pay when you get a longer-term *[insert number of days]* supply of a drug.

[If plan has any preferred pharmacies, the chart must be modified to reflect the appropriate member cost-sharing for preferred and non-preferred pharmacies. The plan may also add or remove cost groups as necessary.]

[If plan operates nationally or in multiple service areas, the chart may be modified to allow the option of indicating – either within the chart, or by reference to a separate chart – any

variance in the cost-sharing levels for certain cost groups for plans in different service areas.] [Insert if applicable: The chart lists information for more than one of our plans. The name of the plan you are in is listed on the front page of this booklet. If you aren't sure which plan you are in or if you have any questions, call Member Services.*]*

Your share of the cost when you get a **longer-term** *[insert number of days]* **supply** of a covered Part D prescription drug from:

	Network pharmacy	**The plan's mail-order service**
Cost Group 1 ([*insert description*])	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*
Cost Group 2 ([*insert description*])	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*
Cost Group 3 ([*insert description*])	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*
Cost Group 4 ([*insert description*])	*[Insert copay/ coinsurance]*	*[Insert copay/ coinsurance]*

Chapter 6
Section 5.4

You stay in the Initial Coverage Stage until your total drug costs for the year reach $[*insert initial coverage limit*]

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$[*insert initial coverage limit*] limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what the plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. This includes:
  - *[Plans without a deductible, omit:]* The $[*insert deductible amount*] you paid when you were in the Yearly Deductible Stage.
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage Stage.

[*Insert if applicable:* We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs. [*Insert only if plan pays for OTC drugs as part of its administrative costs:* We also provide some over-the-counter medications exclusively for your use. These over-the-counter drugs are provided at no cost to you.] To find out which drugs our plan covers, refer to your formulary.]

The *Explanation of Benefits* that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the $[*insert initial coverage limit*] limit in a year.

We will let you know if you reach this $[*insert initial coverage limit*] amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, [*insert as appropriate:* you pay the full cost of your drugs *OR* the plan provides limited drug coverage]

Chapter 6 **Section 6.1** You stay in the Coverage Gap Stage until your out-of-pocket costs reach $[*insert TrOOP amount*]

Once your total out-of-pocket costs reach $[*insert TrOOP amount*], you will qualify for catastrophic coverage.

[*Plans without any gap coverage, insert:* When you are in the coverage gap stage, **you pay the full cost for your drugs**. (Your full cost is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.) You continue paying the full cost until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2010, that amount is $[*insert TrOOP amount*].]

[*Plans offering some gap coverage, insert:* After you leave the Initial Coverage Stage, we will continue to provide some prescription drug coverage until your yearly out-of-pocket costs reach a maximum amount that Medicare has set. In 2010, that amount is $[*insert TrOOP amount*]. [*Plans offering coverage in the coverage gap must describe that coverage.*]]

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $[*insert TrOOP amount]*, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Chapter 6
Section 6.2

How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

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

When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - [*Plans without a deductible, omit:* The Yearly Deductible Stage.]
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any payments you made during this calendar year under another Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, or by a State Pharmaceutical Assistance Program that is qualified by Medicare. Payments made by "Extra Help" from Medicare are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $[*insert TrOOP amount*] in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments are **not included** in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- [*Plans with no premium, omit:]* The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- [*Insert if plan does not provide coverage for excluded drugs as a supplemental benefit:* Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.]

[*Insert next two bullets if plan provides coverage for excluded drugs as a supplemental benefit.]*

- [Prescription drugs covered by Part A or Part B.]
- [Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan.]
- [*Insert if applicable:* Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.]
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by insurance plans and government-funded health programs such as TRICARE, the Veteran's Administration, the Indian Health Service, or AIDS Drug Assistance Programs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are on the cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you**. The *Explanation of Benefits* report we send to you includes the current amount of your out-of-pocket costs (Section 3 above tells about this report). When you reach a total of $[*insert TrOOP amount*] in out-of-pocket costs for the year,

this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.

- **Make sure we have the information we need**. Section 3 above tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Chapter 6 Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $[*insert TrOOP amount*] limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

[Plans insert appropriate option for your catastrophic cost sharing.

Option 1:

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  - –*either* – coinsurance of 5% of the cost of the drug
  - –*or* – $*[Insert 2010 catastrophic cost-sharing amount for generics/preferred multisource drugs]* copayment for a generic drug or a drug that is treated like a generic. Or a $*[Insert 2009 catastrophic cost-sharing amount for all other drugs]* copayment for all other drugs.
- **Our plan pays the rest** of the cost.

Option 2:

[Insert appropriate tiered cost-sharing amounts]. We will pay the rest.

SECTION 8 Additional benefits information

Chapter 6 Section 8.1 Our plan offers additional benefits

[Optional: Insert any additional benefits information based on the plan's approved bid that is not captured in the sections above.]

SECTION 9 What you pay for vaccinations depends on how and where you get them

Chapter 6 Section 9.1 Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a vaccination?

What you pay for a vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical benefits chart (what is covered and what you pay).*
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs.*
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a vaccination shot. [*Insert if applicable:* Remember you are responsible for all of the costs associated with vaccines (including their administration) during the [*insert as applicable:* Deductible Stage OR Coverage Gap Stage *OR* Deductible and Coverage Gap Stage] of your benefit.]

Situation 1: You buy the vaccine at the pharmacy and you get your vaccination shot at the pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your [*insert as appropriate:* coinsurance *OR* copayment *OR* coinsurance or copayment] for the vaccine itself.
- Our plan will pay for the cost of giving you the vaccination shot.

Situation 2: You get the vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking the plan to pay its share of a bill you have received for medical services or drugs*).
- You will be reimbursed the amount you paid less your normal [*insert as appropriate:* coinsurance *OR* copayment *OR* coinsurance or copayment] for the vaccine (including administration) [*Insert the following only if an out-of-network differential is charged:* less any difference between the amount the doctor charges and what we normally pay. (If you are in the Extra Help program, we will reimburse you for this difference.)]

Situation 3: You buy the vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share

of the cost by using the procedures described in Chapter 7 of this booklet.

- You will be reimbursed the amount charged by the doctor less any cost-sharing amount that you need to pay for the vaccine [*Insert the following only if an out-of-network differential is charged:* less any difference between the amount the doctor charges and what we normally pay. (If you are in the Extra Help program, we will reimburse you for this difference.)]

[*Insert any additional information about your coverage of vaccines and vaccine administration.*]

Chapter 6
Section 9.2

You may want to call us at Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination (phone numbers are on the cover of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 10 Do you have to pay the Part D "late enrollment penalty"?

Chapter 6
Section 10.1

What is the Part D "late enrollment penalty"?

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't keep your prescription drug coverage. The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible or how many months after 63 days you went without drug coverage.

The penalty is added to your monthly premium. (Members who choose to pay their premium every three months will have the penalty added to their three-month premium.) When you first enroll in *[insert plan name]*, we let you know the amount of the penalty.

Chapter 6
Section 10.2

How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you had a break in prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For our example, let's say it is 14 months without coverage, which will be 14%
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. [*Insert EITHER:* For 2010, this average premium amount is $[*insert 2010 national base beneficiary premium*] *OR* For 2009, this average premium amount was $[*insert 2009 national base beneficiary premium*]. This amount may change for 2010.]
- You multiply together the two numbers to get your monthly penalty and round it to the nearest 10 cents. In the example here it would be 14% times $[*insert base beneficiary premium*], which equals $[*insert amount*], which rounds to $[*insert amount*]. This amount would be added **to your monthly premium**.

There are three important things to note about this monthly premium penalty:

- First, **the penalty will change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment into Medicare.

Chapter 6
Section 10.3

In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a premium penalty for late enrollment if you are in any of these situations:

- You already have prescription drug coverage at least as good as Medicare's standard drug coverage. Medicare calls this "**creditable drug coverage**." Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your human resources department to find out if your current drug coverage is as at least as good as Medicare's.
- If you were without creditable coverage, you can avoid paying the late enrollment penalty if you were without it for less than 63 days.
- If you didn't receive enough information to know whether or not your previous drug coverage was creditable.
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) – *and* – you signed up for a Medicare prescription drug plan by December 31, 2006 – *and* – you have stayed in a Medicare prescription drug plan.
- You are receiving "Extra Help."

Chapter 6
Section 10.4

What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call Member Services at the number on the front of this booklet to find out more about how to do this.

CHAPTER 7: Asking the plan to pay its share of a bill you have received for covered services or drugs

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

Chapter 7 Section 1.1 If you pay our plan's share of the cost of your covered services or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, 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 the difference between the amount you paid and the amount you owed under the plan.

3. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

- Save your receipt and send a copy to us when you ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

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

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back the difference between the amount you paid and the amount you owed under the plan.

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

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

Chapter 7 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 7
Section 3.1

We check to see whether we should cover the service or drug 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 or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs.)
- If we decide that the medical care or drug 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 and your rights to appeal that decision.

Chapter 7
Section 3.2

If we tell you that we will not pay for the medical care or drug, you can make an appeal

If you think we have made a mistake in turning you down your request for payment, 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 9 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 detailed 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 9. 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 in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.4 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.6 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send them to the plan

Chapter 7 Section 4.1 In some cases, you should send your receipts to the plan to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for catastrophic coverage more quickly.

Here are two situations when you should send us receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than the plan's price

Sometimes when you are in the Coverage Gap Stage [*insert if applicable:* or Deductible Stage] you can buy your drug for a price that is lower than the plan's price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside the plan's benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are in the Coverage Gap Stage [*insert if applicable:* or Deductible Stage], the plan will not pay for any share of these drug costs. But sending the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, the plan will not pay for any share of these drug costs. But sending the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore you cannot make an appeal if you disagree with our decision.

CHAPTER 8: 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 8 Section 1.1 We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, 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 Braille, 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 8 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 8
Section 1.3

We must ensure that you get timely access to your covered services and drugs

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. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 of this booklet tells what you can do.

Chapter 8
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 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 may 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.
- Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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 8
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 including our network pharmacies.**

- For example, you have the right to get information from us about the qualifications of the providers and pharmacies 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 a list of the pharmacies in the plan's network, see the *Pharmacy Directory*.
- For more detailed information about our providers or pharmacies, 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.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - 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 or Part D drug 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 or drug from an out-of-network provider or pharmacy.
  - If you are not happy with a decision we make about what medical care or Part D drug 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 9 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 9 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 or a Part D prescription drug, see Chapter 7 of this booklet.

Chapter 8
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. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, 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 9 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 8
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 9 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 9, 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 8
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, sexual orientation, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services'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 8
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 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 You have some responsibilities as a member of the plan

Chapter 8
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.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

- **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 and drug benefits you get from our plan with any other health and drug 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 or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help 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 or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. 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. Chapter 6 tells what you must pay for your Part D prescription drugs.
    - If you get any medical services or drugs 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 [*plans with a continuation area offered, insert "generally" here and then explain the continuation area]* 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 9: 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

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

SECTION 7. How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon

SECTION 8. How to ask our plan to keep covering certain medical services if you think your coverage is ending too soon

Background

SECTION 1 Introduction

Chapter 9
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 9
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 simpler 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" or "coverage 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 9
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

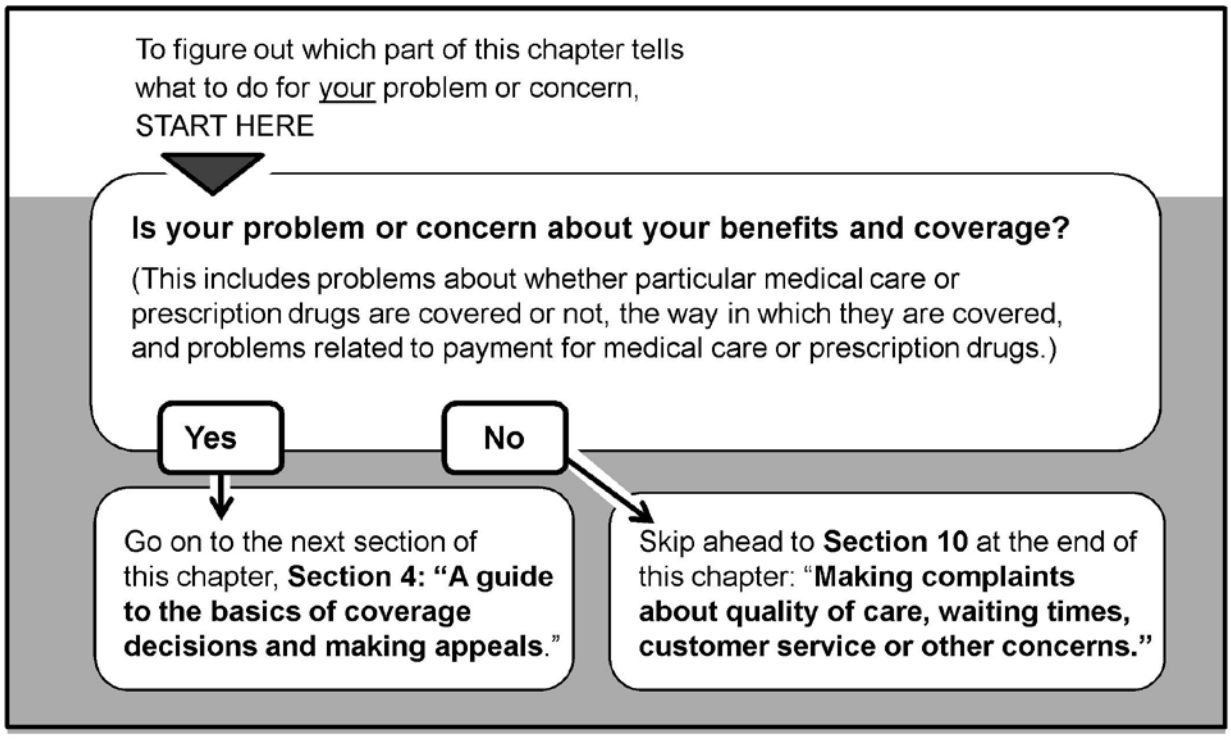
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- 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 (www.medicare.gov).

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

Chapter 9 Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use 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 9
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 and prescription drugs, 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 or drugs. 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.

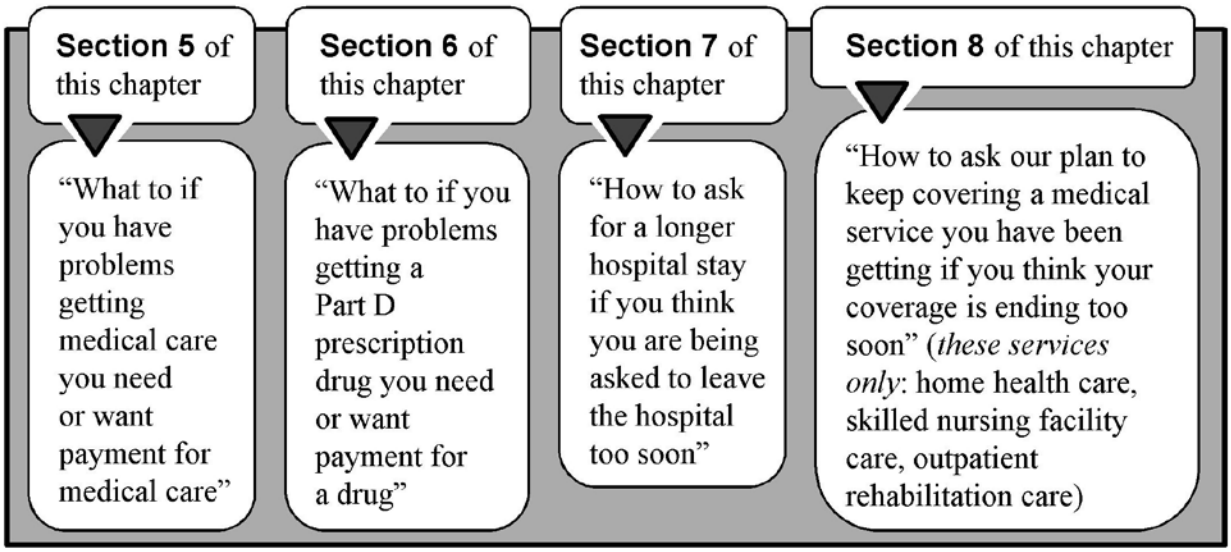
Chapter 9 **Section 4.2** How to get help when you are asking for a coverage decision or making an appeal

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 or other provider involved.** In most situations involving a coverage decision or appeal, your doctor or other provider 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 provider, 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.

Chapter 9 **Section 4.3** Which section of this chapter gives the details for <u>your</u> situation?

There are four 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 9
Section 5.1

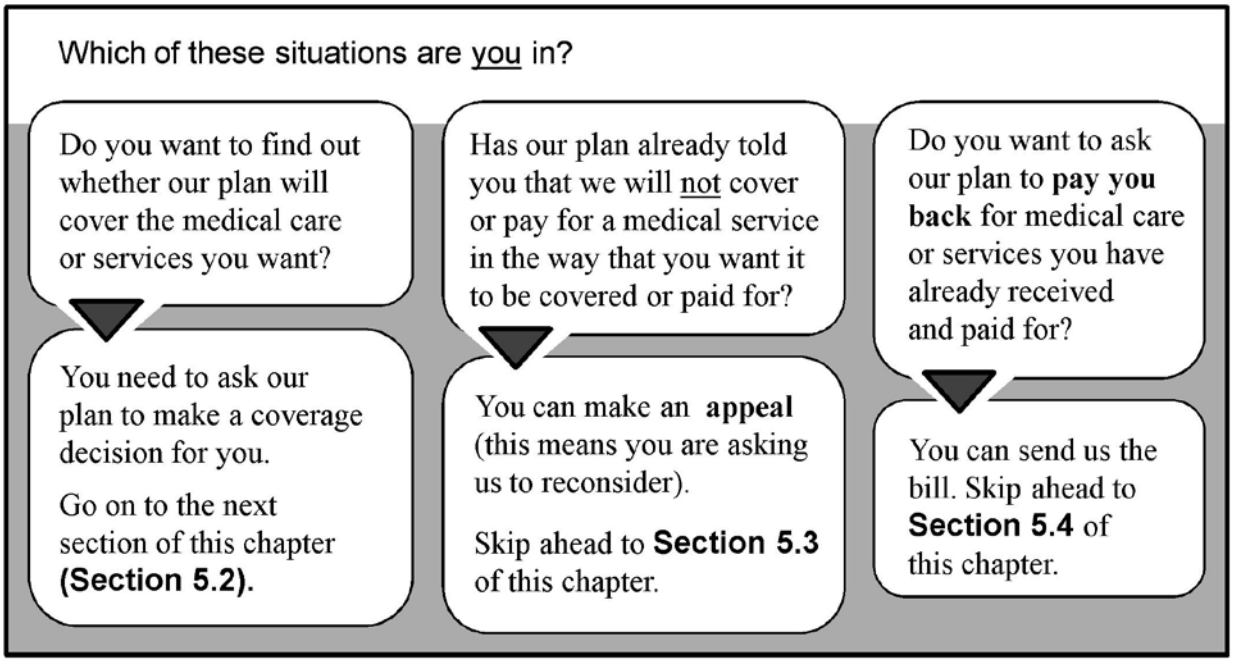
This section tells what to do if you have problems getting medical care or if you want us to pay you back for our share of the cost of your care

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 outpatient rehabilitation care**, 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 9, Section 7: *How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
        - Chapter 9, Section 8: *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 outpatient rehabilitation 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 9
Section 5.2

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

Legal terms

A coverage decision is often 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 should 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

information about the process for making complaints, including fast complaints, see Section 10 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 information about the process for making complaints, including fast complaints, see Section 10 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 information about the process for making complaints, including fast complaints, see Section 10 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 take 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 9
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 *[plan may edit section title as needed:]* (*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"

Legal terms

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.

Chapter 9
Section 5.4

Step-by-step: How to make a Level 2 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 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Chapter 9
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 information 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 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

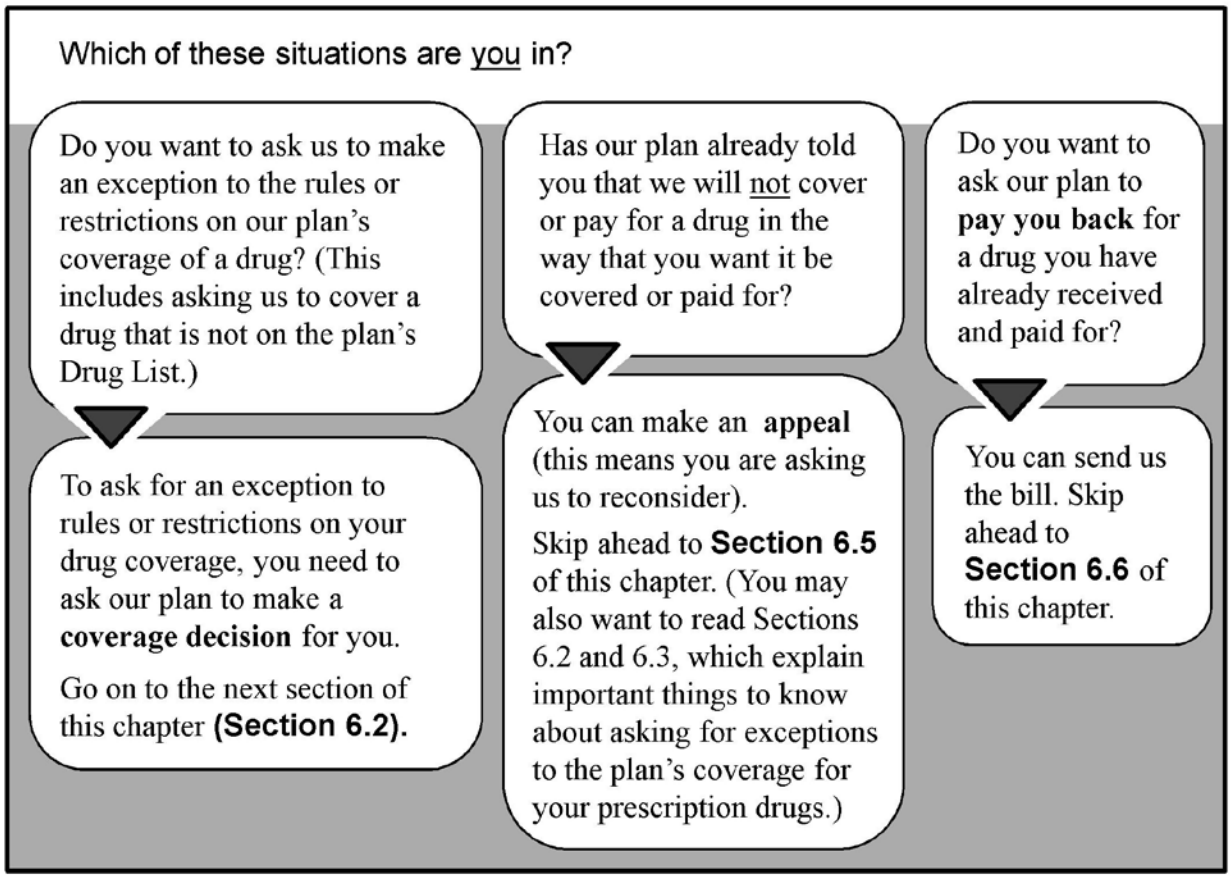
Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Chapter 9 **Section 6.1** This section tells what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's *List of Covered Drugs (Formulary)* and they are

medically necessary for you, as determined by your primary care doctor or other provider in the plan's network.

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).



Chapter 9
Section 6.2

What are some examples of exceptions to the coverage rules?

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an "exception" to our coverage rules. An exception is a type of coverage decision. Similar to

other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception to our Part D drug coverage rules, your doctor will need to explain the medical reasons. We will then consider your request. Here are three examples of exceptions that you or your doctor can ask us to make:

1. **Make an exception to the rules and cover a Part D drug for you that is not on our plan's *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)

   Legal terms

   Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to [*insert as appropriate:* all of our drugs OR drugs in *[insert exceptions cost group]]*. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.
   - You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

2. **Make an exception to the rules by removing a restriction on the plan's coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on the plan's *List of Covered Drugs* (for more information, go to Chapter 5 and look for Section 5).

   Legal terms

   Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

   - The extra rules and restrictions on coverage for certain drugs include:
     - *[Omit if plan does not use generic substitution] Being required to use the generic version* of a drug instead of the brand-name drug.
     - *[Omit if plan does not use prior authorization] Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - *[Omit if plan does not use step therapy] Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")]
     - *[Omit if plan does not use quantity limits] Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
   - If our plan agrees to make an exception and waive a restriction for you, you can ask for another exception to change the Cost Group for that drug.

3. [*Plans without drug cost groups should omit this section]* **Make an exception to the rules by changing coverage of a drug to a lower Cost Group.** Every drug on the plan's Drug List is in one of *[insert number of cost groups]* Cost Groups. In general, the lower the Cost Group number, the less you will pay as your share of the cost of the drug.

Since Cost Groups are sometimes called "tiers," asking for a change to the Cost Group is sometimes called asking for a **"tiering exception."**

- If your drug is in [*insert name of non-preferred/highest cost group subject to the tiering exceptions process*] you can ask us to cover it at the cost-sharing amount that applies to drugs in [*insert name of preferred/lowest cost group subject to the tiering exceptions process]*. This would lower your share of the cost for the drug.
- [*If the Plan designated one of its cost groups as a "high-cost/unique drug cost group" and is exempting that cost group from the exceptions process, include the following language:* You cannot ask us to change the Cost Group for any drug in [*insert cost group number and name of cost group designated as the high-cost/unique drug cost group*].]
- If our plan agrees to make an exception and cover a drug for you that is not on our Drug List, you cannot ask for a change to the Cost Group for that drug.
- If our plan agrees to make an exception and waive a restriction for you, you can ask for another exception to change the Cost Group for that drug.

Chapter 9
Section 6.3

Important things to know about asking for exceptions to the rules for coverage of Part D drugs

Who can ask for an exception?

You or your doctor or someone else who is acting on your behalf can ask for an exception to our rules for coverage of your Part D drugs. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.)

Your doctor must tell us the medical reasons

Your doctor must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from the doctor when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

Our plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

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).

Chapter 9
Section 6.4

Step-by-step: How to ask for an exception
(how to ask our plan to make an exception for you)

Legal terms

An exception is a type of coverage decision. A coverage decision is often called an "**initial determination**" or "initial decision." When the coverage decision is about your Part D drugs, the initial determination is called a "**coverage determination**."

Step 1 ➔ **You ask our plan to make an exception to the plan's rules for drug coverage.** When you ask us to make this exception, *you are asking us to make a coverage decision* about your drugs. If your health requires a quick response, you must ask us to make a **"fast decision."**

What to do

- **Request the exception you want.** Start by [*insert if applicable:* calling,] writing, or faxing our plan to make your request for an exception. You, your representative, or your doctor (or other prescriber) can do this (see Section 6.2 above). For the details, 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 Part D prescription drugs*.
- **Provide the "doctor's statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the

"doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement.

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

Legal terms

A "fast decision" is called an "**expedited 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 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for an exception for a *drug you have not yet received*. (You cannot get a fast decision if your request is about a drug you are already taking.)
  - 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 or other prescriber 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 (or other prescriber'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 or other prescriber asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2 ➔ Our plan considers your request for a drug coverage exception and we give you our answer.

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

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - (If we do not meet this deadline, 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 exception we have agreed to provide within 24 hours. Generally, this means within 24 hours after we receive your doctor's statement supporting your request.
- **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

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
- **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. Generally, this means within 72 hours after we receive your doctor's statement supporting your request.
- **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 a drug coverage exception, you decide if you want to make an appeal

- If our plan says no, you have the right to make an appeal. Making an appeal means making another try to get the exception you want. It means asking us to reconsider – and possibly change – the decision we made.

Chapter 9
Section 6.5

Step-by-step: How to make a Level 1 Appeal

(how to ask for a review of a coverage decision made by our plan)

Legal terms

When you start the appeals 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 Part D drug coverage decision is called a plan "**redetermination**."

Step 1 ➔ You contact our plan and make your level 1 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 representative or your doctor or other prescriber) must contact our plan.**
  - For details on how to reach us by phone, fax, mail, or in person for any purpose related to your appeal, 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 Part D prescription drugs.*
- **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 Part D prescription drugs*).]
- **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.**
  - 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 or other prescriber may give us additional information to support your appeal.

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

Legal terms

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

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- *[Plans with the same process for requesting expedited coverage decisions and expedited appeals, insert:]* 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 that are given in Section 6.4 of this chapter.
- *[Plans with a different process for requesting expedited coverage decisions and expedited appeals, insert description of process for requesting expedited appeals here.]*

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 an exception to the drug coverage rules. We check to see if we were being fair and following all the rules when we said no to your request. We may contact you or your doctor to get more information.

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

- If 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 it.
  - If we do not give you an answer within 72 hours, 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 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 and how to appeal our decision.

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

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 7 calendar 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 as quickly as your health requires, but no later than 7 calendar 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 and how to appeal our decision.

Step 3 ➔ If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Chapter 9
Section 6.6

Step-by-step: How to make a Level 2 Appeal

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a 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 ➔ To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, 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.]

Step 2 ➔ The Independent Review Organization does a review of your appeal and gives you an answer.

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

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.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

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.

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

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means they agree with our plan that your request 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 drug 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Chapter 9
Section 6.7

What if you are asking our plan to pay you back for our share of the cost of a drug you have paid for?

If you want to ask our plan to pay you back for a drug, 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. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

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 information about coverage decisions, see Section 4.2 of this chapter). To make this coverage decision, we will check to see if the drug you paid for is a covered drug. We will also check to see if you followed all the rules for using your coverage for drugs (these rules are given in Chapter 6 of this booklet).

We will say yes or no to your request

- If the drug is covered and you followed all the rules, we will send you the payment for our share of the cost of your drug. (When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
    - *[Plans with no deductible or coverage gap, omit this bullet.]* NOTE: It is possible that you followed all the rules but you are in [*insert as applicable:* the Deductible Stage *OR* the Coverage Gap Stage *OR* either the Deductible Stage or the Coverage Gap Stage.] In [*insert as applicable:* this period *OR* either of those periods], you pay the full cost of your drugs until you qualify for the next period. If you have followed all the rules, we will count your payment towards your out-of-pocket total even though we cannot reimburse you. (For more information about the [*insert as applicable:* Deductible Stage *OR* Coverage Gap Stage *OR* Deductible Stage and Coverage Gap Stage], see Chapter 6.)
- If the drug is *not* covered, or you did *not* follow all the rules, we will not reimburse you. Instead, we will send you a letter that says we will not reimburse you and explains why. (When we turn down your request for reimbursement, it's the same as saying *no* to your request for a coverage decision.)

What if you ask us to reimburse you and we say that we will not?

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 reimbursement.

To make this appeal, follow the process for appeals that we describe in section 6.5 of this chapter. See Section 6.5 in this chapter 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 requesting payment for a drug you have already received, 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 provide the reimbursement you have requested. We are required to send payment to you **within 30 days**.

SECTION 7 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 9 **Section 7.1** 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.

Legal terms

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 7.2 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 www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage

Chapter 9
Section 7.2

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**.

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 7.3.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

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

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.

> Legal terms
>
> 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 9
Section 7.3

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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Chapter 9
Section 7.4

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

You can appeal to our plan instead

As explained above in Section 7.2, 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.

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 with you that you still need to be in the hospital after the discharge date, and will 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 ends as of the day we said coverage would end.

- 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.

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 10 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 72 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask our plan to keep covering certain medical services if you think your coverage is ending too soon

Chapter 9
Section 8.1

This section is about three services <u>only</u>:

Home health care, skilled nursing facility care, and outpatient rehabilitation care

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 rehabilitation facility. Usually, this means you are getting treatment for

an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *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 ask us to keep covering the care for a longer time** and we will consider your request. This section tells you how to ask.

Chapter 9
Section 8.2

We will 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 letter or 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 information 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 9.3 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 9
Section 8.3

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 10 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.

Legal terms

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.

You have one of two deadlines.

- Your deadline for contacting the Quality Improvement Organization depends on when you receive the written notice telling when coverage for your care will end.
    - If you get the written notice 2 days before your coverage ends, you must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you get the notice.*
    - If you get the notice *more than* 2 days before your coverage ends, you must 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 8.4.)

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 explanation from the plan that gives our reasons for wanting to end the plan's coverage for your services.

This written explanation 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 9
Section 8.4

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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Chapter 9
Section 8.5

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

You can appeal to our plan instead

As explained above in Section 9.3, 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:

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 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 with you that you need services longer, and will 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 outpatient rehabilitation care *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 1 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 72 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

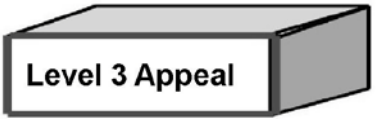
SECTION 9 Taking your appeal to Level 3 and beyond

Chapter 9 Section 9.1 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.

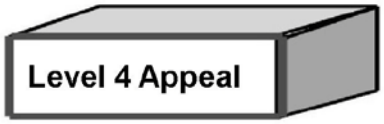
If the dollar value of the drug or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive 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.



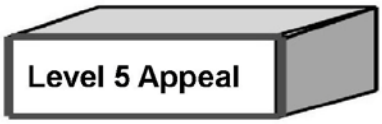
A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **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 can continue to the next level of the review process. If the administrative judge says no to your appeal, the notice you get will tell you 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.

- This is the last stage of the appeals process.

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 10 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 9
Section 10.1

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?

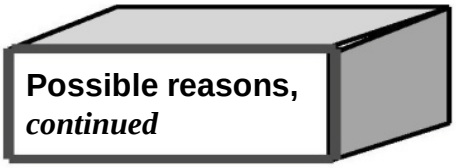
Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long:
  - By doctors, pharmacists, 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, in the exam room, or when getting a prescription.

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?

The next page has more examples of possible reasons for making a complaint



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 4-9 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 or drugs, 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 Reviewer. If we don't do that within the required deadline, you can make a complaint.

Chapter 9
Section 10.2

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 9
Section 10.3

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 you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **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. Our response will include our reasons for this answer.

Chapter 9
Section 10.4

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 10: Ending your membership in the plan

SECTION 1 Introduction

[Dual eligible SNPs may modify this chapter as necessary to reflect members' continuous rights to change plans.]

Chapter 10
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 10
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 Coordinated 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.

    Note: If you disenroll from a Medicare prescription drug plan and go without 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.)

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

Chapter 10
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 with prescription drug coverage, this means that you can enroll in *either*:
  - Another Medicare Advantage plan with prescription drug coverage

- ***– or –*** Original Medicare and a separate prescription drug plan.

- **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 10 **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 are eligible for Extra Help with paying for your Medicare prescriptions.
  - If you live in a facility, such as a nursing home.

- **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.

    Note: If you disenroll from a Medicare prescription drug plan and go without 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.)

- **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 10
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. TTY users should call 1-877-486-2048.

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

Chapter 10
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.

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

Chapter 10 **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 and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy [*insert if applicable:* including through our mail-order pharmacy services.]

- **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 10 **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.

- 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.]

- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.

- [*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 10
Section 5.2

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

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 10
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 9, Section 10 for information about how to make a complaint.

CHAPTER 11: 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 12: 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 12 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 something you do if you disagree with a decision to deny a request for health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug, item, or service you think you should be able to receive. Chapter 9 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.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $[*insert TrOOP amount*] in covered drugs during the covered year.

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

Comprehensive Outpatient Rehabilitation Facility – 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 Group – Every drug on the list of covered drugs is in one of *[insert number of cost groups]* Cost Groups. In general, the higher the Cost Group number, the higher your cost for the drug

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

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

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

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 cover, 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 medical services or drugs.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

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.

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

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

Grievance - A type of complaint you make about us or one of our network providers or 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.

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

Initial Coverage Stage – This is the stage [*insert if applicable:* after you have met your deductible and] before your total drug expenses, have reached $[*insert initial coverage limit*], including amounts you've paid and what our plan has paid on your behalf.

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

List of Covered Drugs (Formulary) – A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy/Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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

Network provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they [*insert if appropriate:* 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 this definition only if plan has preferred and non-preferred pharmacies] [*Insert either:* **Non-preferred network pharmacy** *OR* **Other network pharmacy**] – A network pharmacy that offers covered drugs to members of our plan at higher cost-sharing levels than apply at a preferred network pharmacy.

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

Organization Determination - The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – The Original Medicare Plan is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under the Original Medicare plan, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share.

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.

Out-of-network pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

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

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

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

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

Primary Care [*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 will generally 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 and/or any drugs.]* 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. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by

Medicare Providers. See Chapter 2 for information about how to contact the QIO in your state and Chapter 9 for information about making complaints to the QIO.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

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, and in the case of network plans, where a network must be available to provide services.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care – 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.