

## EXHIBIT A

### Notice of Denial of Medical Coverage (or Payment) CMS-10003-NDMCP CHANGE CROSSWALK

<b>CURRENTLY APPROVED</b>	<b>CHANGE TO NOTICE</b>	<b>EXPLANATION</b>
<p>On Page 1 under section Why did we deny your request?</p> <p>On Page 2 under section How to ask for an appeal with {health plan name} Step 1:</p> <p>On Page 3 under section “What happens next?”</p>	<p>Changed all terms that stated, “Part B or Medicaid drug” to “Part B drug or Medicaid drug”.</p>	<p>This text was erroneously removed from the notice and is being reinserted to clarify that plans should enter the term “Part B drug” and not “Part B”, when applicable.</p>
<p>The “Fast Appeal” section reads:</p> <p>We’ll give you a decision on a fast appeal within {insert appropriate timeframe for medical service/item or Part B or Medicaid drug: <b>72 hours, 24 hours</b>} after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a {<i>medical service/item or Part B drug</i>} you’ve already received.</p> <p><b>We’ll automatically give you a fast appeal if a doctor asks for one for you or if your doctor</b></p>	<p>Bracketed text related to Part B drug timeframes has been reinserted in both paragraphs of this section to read:</p> <p>We’ll give you a decision on a fast appeal within <b>72 hours</b> [Insert timeframe for expedited internal plan Medicaid appeals, if different] after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to {insert appropriate timeframe for medical service/item or Part B drug: <b>30 days, 7 days</b>} for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a {<i>medical service/item or Part B</i></p>	<p>This bracketed text was erroneously removed from the notice and is being reinserted for accuracy and to account for Part B drug timeframes.</p>

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<p><b>supports your request.</b> If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.</p>	<p><i>drug</i>} you've already received.</p> <p><b>We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request.</b> If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within {insert appropriate timeframe for medical service/item or Part B drug: <b>30 days, 7 days</b>}.</p>	
<p>On page 2, under section <b>“How to ask for an appeal with {health plan name}”</b>: If you're asking for an appeal and missed the deadline, you may include your reason for being late.</p>	<p>If you're asking for an appeal and missed the deadline, you may <b>request an extension and should</b> include your reason for being late.</p>	<p>This text was erroneously removed from the notice and is being reinserted to specify an enrollee may ask for a good cause extension.</p>
<p>On page 3 under section <b>“How to ask for an appeal with {health plan name}”</b>:  <b>For a Standard Appeal:</b>  Mailing Address: {In Person Delivery Address:}  {Phone:}  {TTY Users Call:}  Fax:</p>	<p><b>“How to ask for an appeal with {health plan name}”</b>:  <b>For a Standard Appeal:</b>  Mailing Address: {In Person Delivery Address:}  {Phone:}  {TTY Users Call:}  Fax:</p>	<p>Restored curly brackets around “Phone” under standard appeals. Plans are not required to accept verbal requests for appeals and curly brackets provide plans the option to add a phone number.</p>
<p>On page 3, under section <b>“What happens next?”</b>  If you ask for an appeal, <b>we will send you another letter with a decision to tell you if we approve or deny</b></p>	<p><b>“What happens next?”</b>  ‘If you ask for an appeal and we continue to deny your request for {payment of} a {medical service/item</p>	<p>Removed language regarding enrollees receiving a decision letter because plans are not required to send notification to an enrollee if</p>

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<p><b>your request.</b> If we continue to deny your request for {payment of} a {medical service/item or Part B or Medicaid drug}, we'll <b>send you a written decision and</b> automatically send your case to an independent reviewer.</p>	<p>or Part B drug or Medicaid drug, we'll automatically send your case to an independent reviewer.</p>	<p>a denial is upheld and their case is forwarded to the IRE.</p>