[2021 EOC model]

January 1 – December 31, 2021

Evidence of Coverage:

Your Medicare Health Benefits and Services [*insert if applicable:* **and Prescription Drug Coverage**] as a Member of ***[insert 2021 plan name] [insert plan type]***

*[**Optional:** insert member name]*
*[**Optional:** insert member address]*

This booklet gives you the details about your Medicare health care [*insert if applicable:* and prescription drug] coverage from January 1 – December 31, 2021. It explains how to get coverage for the health care services [*insert if applicable:* and prescription drugs] you need. **This is an important legal document. Please keep it in a safe place.**

This plan, *[insert 2021 plan name]*, is offered by *[insert MAO name] [insert DBA names in parentheses, as applicable, after listing required MAO names throughout this document].* (When this *Evidence of Coverage* says "we," "us," or "our," it means *[insert MAO name] [insert DBA names in parentheses, as applicable, after listing required MAO names throughout this document]*. When it says "plan" or "our plan," it means *[insert 2021 plan name]*.)

[*Plans that meet the 5% alternative language threshold insert:* This document is available for free in *[insert languages that meet the 5% threshold].*

Please contact our Member Services number at *[insert phone number]* for additional information. (TTY users should call *[insert TTY number]*.) Hours are *[insert days and hours of operation]*.

[Plans must insert language about availability of alternate formats (e.g., braille, large print, audio tapes) as applicable.]

[Remove terms as needed to reflect plan benefits] Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2022.

[Remove terms as needed to reflect plan benefits] The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

[*Insert as applicable: [insert Material ID]* CMS Approved [MMDDYYYY]
OR [insert Material ID] File & Use [MMDDYYYY]]

2021 Evidence of Coverage

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Getting started as a member

Chapter 1. Getting started as a member

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SECTION 1 Introduction

Section 1.1 You are enrolled in *[insert 2021 plan name]*, which is a Medicare Private Fee-for-Service Plan

You are covered by Medicare, and you have chosen to get your Medicare health care [*insert if applicable:* and your prescription drug coverage] through our plan, *[insert 2021 plan name]*.

There are different types of Medicare health plans. *[Insert 2021 plan name]* is a Medicare Advantage Private Fee-for-Service (PFFS) Plan. [*Insert if applicable:* This plan does not include Part D prescription drug coverage.] Like all Medicare health plans, this Medicare PFFS plan is approved by Medicare and run by a private company.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual requirement for QHC.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care [*insert if applicable:* and prescription drugs] covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered services" refers to the medical care and services [*insert if applicable:* and the prescription drugs] available to you as a member of *[insert 2021 plan name]*.

It's important for you to learn what the plan's 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 (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *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 2021 plan name]* covers your care. Other parts of this contract include your enrollment form, [*insert if applicable:* the *List of Covered Drugs (Formulary)*], and any notices you receive from us about changes to your coverage or conditions that 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 2021 plan name]* between January 1, 2021 and December 31, 2021.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of *[insert 2021 plan name]* after December 31, 2021. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2021.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve *[insert 2021 plan name]* each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- *and* -- You live in our geographic service area (Section 2.3 below describes our 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 are still eligible as long as you have not moved since before January 1999.]
- *and* -- you are a United States citizen or are lawfully present in the United States

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, 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) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for *[insert 2021 plan name]*

Although Medicare is a Federal program, *[insert 2021 plan name]* is available only to individuals who live in our plan service area. To remain a member of our plan, you *[if a*

"continuation area" is offered under 42 CFR 422.54, insert "generally" here, and add a sentence describing the continuation area] must continue to reside in the plan service area. The service area is described [*insert as appropriate:* below *OR* in an appendix to this *Evidence of Coverage*].

[*Insert plan service area here or within an appendix. Plans may include references to territories, as appropriate. Use the county name only if approved for the entire county. For an approved partial county, use the county name plus the approved zip code(s). Examples of the format for describing the service area are provided below. If needed, plans may insert more than one row to describe their service area.*

Our service area includes all 50 states
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]*]

[*Optional info: multi-state plans may include the following:* We offer coverage in [*insert as applicable:* several *OR* all] states [*insert if applicable:* and territories]. However, there may be cost or other differences between the plans we offer in each state. If you move out of state [*insert if applicable:* or territory] and into a state [*insert if applicable:* or territory] that is still within our service area, you must call Member Services in order to update your information. *[National plans delete the rest of this paragraph]* If you move into a state [*insert if applicable:* or territory] outside of our service area, you cannot remain a member of our plan. Please call Member Services to find out if we have a plan in your new state [*insert if applicable:* or territory].]

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify *[insert 2021 plan name]* if you are not eligible to remain a member on this basis. *[Insert 2021 plan name]* must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care [*insert if applicable:* **and prescription drugs**]

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

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan [*insert if applicable:* and for prescription drugs you get at network pharmacies]. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

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

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your *[insert 2021 plan name]* membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your *[insert 2021 plan name]* 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. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 3.2 The *Provider Directory*: Your guide to all providers in the plan's network

[Note: PFFS plans without a provider network can exclude this section.]

[Plans with combined provider and pharmacy directories may combine and edit the provider and pharmacy directory sections (including section titles) to describe the combined document. Plans should renumber sections as needed and revise references to "Provider Directory" to use the actual name of the document throughout the model.]

The *Provider Directory* lists our network providers [*insert if applicable*: and durable medical equipment suppliers].

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, [*insert if applicable*: durable medical equipment suppliers,] hospitals, and other health care facilities we have agreements with to deliver [*insert if applicable:* certain] covered services to members in our plan. These providers have already agreed to see members of our plan. See Chapter 3, Section 1.2 for information about the rules for getting your covered services under our plan. [*Insert as applicable*: We included a copy of our Provider Directory in the envelope with this booklet.] [Insert as applicable: We [insert as applicable: also] included a copy of our Durable Medical Equipment Supplier Directory in the envelope with this booklet.] [The most recent list of providers [insert as applicable: and suppliers] is [*insert as applicable*: also] available on our website at *[insert URL]*.]

[*Full network PFFS plans insert:* We have network providers for all services covered under Original Medicare *[indicate if network providers are available for any non-Medicare covered services]*. You can still receive covered services from out-of-network providers (those who do not have an agreement with our plan), as long as those providers agree to accept our plan's terms and conditions of payment, as described in Chapter 3, Section 1.2.]

[*Partial network PFFS plans insert*: We have network providers for *[indicate what category or categories of services for which network providers are available]*. You can still receive covered services from out-of-network providers (those who do not have an agreement with our plan), as long as those providers agree to accept our plan's terms and conditions of payment, as described in Chapter 3, Section 1.2. For services for which network providers are not available, you can receive covered services from any provider who agrees to accept our plan's terms and conditions of payment, as described in Chapter 3, Section 1.2.]

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

There are several reasons why it is important for you to know whether our plan uses a network and if so, which providers are part of the plan's network:

A network provider must furnish you care while an out-of-network provider has the right to refuse to treat you;

[Insert if applicable] A network provider will charge less cost-sharing than an out-of-network provider. *[Partial and full network PFFS plans should describe whether or not the plan has established any higher cost-sharing requirements if the member obtains a covered service from a deemed (out-of-network) provider.]* [*Insert the following sentence if the plan includes such differential cost-sharing:* The amount of cost-sharing you pay a provider who is not one of our network providers may be more than the cost-sharing you pay a network provider. In the plan's Medical Benefits Chart in Chapter 4 of this booklet, we indicate the services for which the cost-sharing amount differs between network providers and out-of-network providers.]

Our plan will pay for all services that you receive from a network provider (including services you receive from an out-of-network provider when you are directed to see that provider by the plan or a network provider). If you decide to see an out-of-network provider who accepts our

plan's terms and conditions of payment on your own, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan. [*Insert as applicable:* Chapter 7 *OR* Chapter 9] 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.

In our plan's network, we must provide a sufficient number and range of providers to meet your needs.

[Note: Plans without a provider directory exclude following paragraph.]

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

Section 3.3 The *Pharmacy Directory*: Your guide to pharmacies in our network

[PFFS plans without Part D coverage may omit this section.]

[Plans with combined provider and pharmacy directories may combine and edit the provider and pharmacy directory sections (including section titles) to describe the combined document. Plans should renumber sections as needed and revise references to the "Pharmacy Directory" to use the actual name of the document throughout the model.]

What are "network pharmacies"?

Network pharmacies are 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. *[Insert applicable section: For a plan that has changes in its pharmacy network]* There are changes to our network of pharmacies for next year. [*Insert if applicable:* We included a copy of our Pharmacy Directory in the envelope with this booklet.] An updated Pharmacy Directory is located on our website at *[insert URL]*. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network**.

OR

[For a plan that will have a higher than normal number of pharmacies leaving its pharmacy network] Our network has changed more than usual for 2021. [*Insert if applicable:* We included a copy of our Pharmacy Directory in the envelope with this booklet.] An updated Pharmacy Directory is located on our website at *[insert URL]*. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **We strongly suggest that you review our current Pharmacy Directory to see if your pharmacy is still in our network.** This is important because, with few exceptions, you must get your prescriptions filled at a network pharmacy if you want our plan to cover (help you pay for) them.

[*Insert if plan has pharmacies that offer preferred cost-sharing in its network:* The *Pharmacy Directory* will also tell you which of the pharmacies in our network have preferred cost-sharing, which may be lower than the standard cost-sharing offered by other network pharmacies for some drugs.]

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). 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.]*

Section 3.4 The plan's List of Covered Drugs (Formulary)

[PFFS plans without Part D coverage may omit this section.]

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 under the Part D benefit included in *[insert 2021 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 2021 plan name]* Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide 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 printed on the back cover of this booklet).

Section 3.5 The *Part D Explanation of Benefits* (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs

[PFFS plans without Part D coverage may omit this section.]

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

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower cost options. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Part D Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet).

[Note: Plans may insert other methods that members can get their Part D Explanation of Benefits.]

SECTION 4 Your monthly premium for *[insert 2021 plan name]*

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. [*Select one of the following:* For 2021, the monthly premium for *[insert 2021 plan name]* is *[insert monthly premium amount]; OR* The table below shows the monthly plan premium amount for each region we serve; *OR* The table below shows the monthly plan premium amount for each plan we are offering in the service area*; OR* The monthly premium amount for *[insert 2021 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.]*] In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

[*Plans with no premium should replace the preceding paragraph with:* You do not pay a separate monthly plan premium for *[insert 2021 plan name]*. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).]

[*Insert if applicable:* Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.]

In some situations, your plan premium could be <u>less</u>

[MA-only plans and plans with no monthly premium: Omit this subsection.]

[*Insert as appropriate, depending on whether SPAPs are discussed in Chapter 2:* There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs; *OR* The "Extra Help" program helps people with limited resources pay for their drugs.] Chapter 2, Section 7 tells more about [*insert as*

applicable: these programs *OR* this program]. If you qualify, enrolling in the program might lower your monthly plan premium.

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

In some situations, your plan premium could be more

[MA-only plans that do not offer optional supplemental benefits, may delete this section.]

[*MA-only plans that offer optional supplemental benefits replace the text below with the following:* In some situations, your plan premium could be more than the amount listed above in Section 4.1. 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 (phone numbers are printed on the back cover of this booklet). *[If the plan describes optional supplemental benefits within Chapter 4, then the plan must include the premium amounts for those benefits in this section.]*]

In some situations, your plan premium could be more than the amount listed above in Section 4.1. [*Insert as appropriate:* These situations are *OR* This situation is] described below.

- [*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 (phone numbers are printed on the back cover of this booklet). *[If the plan describes optional supplemental benefits within Chapter 4, then the plan must include the premium amounts for those benefits in this section.]*]
- *[MA-only plans, omit]* Some members are required to pay a Part D **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 have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.
    - If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. Chapter 1, Section 5 explains the Part D late enrollment penalty.

- If you have a Part D late enrollment penalty and do not pay it, you could be disenrolled from the plan.

- Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA, because, 2 years ago, they had a modified adjusted gross income, above a certain amount, on their IRS tax return. Members subject to an IRMAA will have to pay the standard premium amount and this extra charge, which will be added to their premium. Chapter 1, Section 6 explains the IRMAA in further detail.

SECTION 5 Do you have to pay the Part D "late enrollment penalty"?

[PFFS plans that do not offer Part D: omit Section 5, re-number remaining sections in Chapter 1, and change cross-references to section numbers.]

Section 5.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a lifetime Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. *[Plans that do not allow quarterly premium payments, omit the next sentence]* (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 2021 plan name]*, we let you know the amount of the penalty.

Your Part D late enrollment penalty is considered part of your plan premium. [*Insert the following text if the plan disenrolls for failure to pay premiums*: If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium.]

[*Plans with no plan premium, replace the previous two paragraphs with the following language:* When you first enroll in *[insert 2021 plan name]*, we let you know the amount of the penalty. Your Part D late enrollment penalty is considered your plan premium. [*Insert the following text if the plan disenrolls for failure to pay premiums*: If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.]]

Section 5.2 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 did not have creditable 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 example, if you go 14 months without coverage, the penalty 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 2021, this average premium amount is $*[insert 2021 national base beneficiary premium] OR* For 2020, this average premium amount was $*[insert 2020 national base beneficiary premium]*. This amount may change for 2021.]
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $*[insert base beneficiary premium]*, which equals $*[insert amount]*. This rounds to $*[insert amount]*. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may 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, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 5.3 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 Part D late enrollment penalty.

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

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human

resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

- Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.

- The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
- For additional information about creditable coverage, please look in your *Medicare & You 2021* Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 5.4 What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. If you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

[*Insert the following text if the plan disenrolls for failure to pay premiums*: **Important:** Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.]

SECTION 6 Do you have to pay an extra Part D amount because of your income?

[PFFS plans that do not offer Part D: omit Section 6, re-number remaining sections in Chapter 1, and change cross-references to section numbers.]

Section 6.1 Who pays an extra Part D amount because of income?

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 6.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required by law to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 7 More information about your monthly premium

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.]

[*Plans with no monthly premium, omit:* In addition to paying the monthly plan premium,] many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan,** will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit www.medicare.gov on the Web or call 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 may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2021* gives information about the Medicare premiums in the section called "2021 Medicare Costs." This explains how the Medicare Part B [*MA-PD plans insert:* and Part D premiums differ] [*MA-only plans insert:* 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 2021* from the Medicare website (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.

Section 7.1 There are several ways you can pay your plan premium

[MA-only plans indicating in Section 4.1 that there is no monthly premium: Delete this section.]

[MA-PD plans indicating in Section 4.1 that there is no monthly premium: Rename this section, "If you pay a Part D late enrollment penalty, there are several ways you can pay your penalty," and use the alternative text as instructed below.]

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.]*

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

[*MA-PD plans without a monthly premium: Replace the preceding two paragraphs with the following:* If you pay a Part D late enrollment penalty, there are *[insert number of payment options]* ways you can pay the penalty. *[Plans must indicate how the member can inform the plan of their premium payment option choice and the procedure for changing that choice.]*

If you decide to change the way you pay your Part D late enrollment your penalty, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your Part D late enrollment penalty is paid on time.]

Option 1: You can pay by check

[Insert plan specifics regarding premium/penalty payment intervals (e.g., monthly, quarterly- please note that members 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). It should be emphasized that checks should be made payable to the plan and not CMS nor 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 checking or savings account, charged directly to your credit or debit card, or billed each month directly by the plan). Insert information on the frequency of automatic deductions (e.g., monthly, quarterly – please note that members 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. Please note that furnishing discounts for members who use direct payment electronic payment methods is prohibited.]

[Include the option below only if applicable. SSA only deducts plan premiums below $300.]

Option *[insert number]*: You can have the [*plans with a premium insert:* **plan premium**] [*plans without a premium insert:* **Part D late enrollment penalty**] taken out of your monthly Social Security check

You can have the [*plans with a premium insert:* plan premium] [*plans without a premium insert:* Part D late enrollment penalty] taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your [*plans with a premium insert:* plan premium] [*plans without a premium insert:* penalty] this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

What to do if you are having trouble paying your [*plans with a premium insert:* plan premium] [*plans without a premium insert:* Part D late enrollment penalty]

[Plans that do not disenroll members for non-payment may modify this section as needed.]

Your [*plans with a premium insert:* plan premium] [*plans without a premium insert:* Part D late enrollment penalty] is due in our office by the *[insert day of the month]*. If we have not received your [*plans with a premium insert:* premium] [*plans without a premium insert:* penalty] payment 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 [*plans with a premium insert:* premium] [*plans without a premium insert:* Part D late enrollment penalty] within *[insert length of plan grace period]*. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your [*plans with a premium insert:* premium] [*plans without a premium insert:* Part D late enrollment penalty] on time, please contact Member Services to see if we can direct you to programs that will help with your [*plans with a premium insert:* plan premium] [*plans without a premium insert:* penalty]. (Phone numbers for Member Services are printed on the back cover of this booklet.)

If we end your membership because you did not pay your [*plans with a premium insert:* plan premium] [*plans without a premium insert:* Part D late enrollment penalty], you will have health coverage under Original Medicare.

[*MA-PD plans insert:* If we end your membership with the plan because you did not pay your [*plans with a premium insert:* premium] [*plans without a premium insert:* Part D late enrollment penalty], and you don't currently have prescription drug coverage then you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. During the annual Medicare open enrollment period, you may either join a stand-alone prescription drug plan or a health plan that also provides drug coverage. (If you go without "creditable" drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)] [*Insert if applicable:* At the time we end your membership, you may still owe us for [*plans with a premium insert:* premiums] [*plans without a premium insert:* the penalty] you have not paid. [*Insert one or both statements as applicable for the plan:* We have the right to pursue collection of [*plans with a premium insert:* the premiums] [*plans without a premium insert:* the penalty amount] you owe. *AND/OR* In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.]]

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. [*Insert as applicable:* Chapter 9 *OR* Chapter 7], [*insert as applicable:* Section 10 *OR* Section 7] of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your [*plans with a premium insert:* plan premium] [*plans without a premium insert:* Part D late enrollment penalty] within our grace period, you can ask us to reconsider this decision by calling

[insert phone number] between *[insert hours of operation]*. TTY users should call *[insert TTY number]*. You must make your request no later than 60 days after the date your membership ends.

Section 7.2 Can we change your monthly plan premium during the year?

No. [*Plans with no premium replace next sentence with the following:* We are not allowed to begin charging a monthly plan premium during the year.] 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 September and the change will take effect on January 1.

[MA-only plans: delete this paragraph] 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. 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.

[*MA-PD plans with no premium replace paragraph above with the following:* However, in some cases, you may need to start paying or may be able to stop paying a late enrollment penalty. (The late enrollment penalty may apply if you had a continuous period of 63 days or more when you didn't have "creditable" prescription drug coverage.) This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.]

SECTION 8 Please keep your plan membership record up to date

Section 8.1 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, [*insert if applicable:* 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** [*insert if applicable:* **and drugs**] **are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

[*Non-network PFFS delete paragraph above and replace with:* We use information in your membership record to provide your coverage and to coordinate your benefits with any other insurance you have. Because of this, it is very important that you help us keep your information up to date.]

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
- If you receive care in an out-of-area [*insert if applicable:* or out-of-network] hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet). *[Plans that allow members to update this information on-line may describe that option here.]*

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

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

[Plans collecting information by phone revise heading and section as needed to reflect process.] 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. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or [*insert if applicable:* and 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 printed on the back cover of this booklet).

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to [*insert as applicable:* Chapter 8 *OR* Chapter 6], Section 1.4 of this booklet.

SECTION 10 How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

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SECTION 1 *[Insert 2021 plan name]* contacts (How to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to *[insert 2021 plan name]* Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	*[Insert phone number(s)]* Calls to this number are free. *[Insert days and hours of operation, including information on the use of alternative technologies.]* Member Services also has free language interpreter services available for non-English speakers.
TTY	*[Insert number]* [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. *[Insert days and hours of operation.]*
FAX	*[Optional: 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 and revise the section titles and paragraphs as needed.]

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see [*insert as applicable:* Chapter 7 *OR* Chapter 9] (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions For Medical Care – Contact Information
CALL	*[Insert phone number]* Calls to this number are [*insert if applicable:* not] free. *[Insert days and hours of operation] [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	*[Insert number]* [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. *[Insert days and hours of operation] [Note: If you have a different TTY 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 address here.]* *[**Note**: plans may add email addresses here.]*
WEBSITE	*[Optional: Insert URL]*

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

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see [*insert as applicable:* Chapter 7 *OR* Chapter 9] (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Method	Appeals For Medical Care – Contact Information
CALL	*[Insert phone number]* Calls to this number are [*insert if applicable:* not] free. *[Insert days and hours of operation] [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.]*

Method	Appeals For Medical Care – Contact Information
TTY	*[Insert number]* [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. *[Insert days and hours of operation] [Note: If you have a different TTY 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.]* *[**Note**: plans may add email addresses here.]*
WEBSITE	*[Optional: Insert URL]*

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

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see [*insert as applicable:* Chapter 7 *OR* Chapter 9] (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Method	Complaints About Medical Care – Contact Information
CALL	*[Insert phone number]* Calls to this number are [*insert if applicable:* not] free. *[Insert days and hours of operation] [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	*[Insert number]* [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. *[Insert days and hours of operation] [Note: If you have a different TTY number for accepting expedited grievances, also include that number here.]*

Method	Complaints About Medical Care – Contact Information
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.]* *[**Note**: plans may add email addresses here.]*
MEDICARE WEBSITE	You can submit a complaint about *[insert 2021 plan name]* directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

[Note: MA-only plans may delete this section.]

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. 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*).

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	*[Insert phone number]* Calls to this number are [*insert if applicable:* not] free. *[Insert days and hours of operation] [Note: You may also include reference to 24-hour lines here.] [Note: If you have different numbers for accepting standard and expedited coverage determinations, include both numbers here.]*
TTY	*[Insert number]* [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. *[Insert days and hours of operation] [Note: If you have different TTY numbers for accepting standard and expedited coverage determinations, include both numbers here.]*

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
FAX	*[Insert fax number] [Note: If you have different fax numbers for accepting standard and expedited coverage determinations, include both numbers here.]*
WRITE	*[Insert address] [Note: If you have different addresses for accepting standard and expedited coverage determinations, include both addresses here.]* *[**Note**: plans may add email addresses here.]*
WEBSITE	*[Insert URL]*

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

[Note: MA-PD plans may delete this section.]

An appeal is a formal way of asking us to review and change a coverage decision we have made. 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*).

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	*[Insert phone number]* Calls to this number are [*insert if applicable:* not] free. *[Insert days and hours of operation] [Note: You may also include reference to 24-hour lines here.] [Note: You are required to accept expedited appeal requests by phone, and may choose to accept standard appeal requests by phone. If you choose to accept standard appeal requests by phone and you have different numbers for accepting standard and expedited appeals, include both numbers here.]*

Method	Appeals for Part D Prescription Drugs – Contact Information
TTY	*[Insert number]* [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. *[Insert days and hours of operation] [Note: You are required to accept expedited appeal requests by phone, and may choose to accept standard appeal requests by phone. If you choose to accept standard appeal requests by phone and you have different TTY numbers for accepting standard and expedited appeals, include both numbers here.]*
FAX	*[Insert fax number] [Note: If you have different fax numbers for accepting standard and expedited appeals, include both numbers here.]*
WRITE	*[Insert address] [Note: If you have different addresses for accepting standard and expedited appeals, include both addresses here.]* *[**Note**: plans may add email addresses here.]*
WEBSITE	*[Insert URL]*

How to contact us when you are making a complaint about your Part D prescription drugs

[Note: MA-only plans may delete section.]

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) 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*).

Method	Complaints about Part D prescription drugs – Contact Information
CALL	*[Insert phone number]* Calls to this number are [*insert if applicable:* not] free. *[Insert days and hours of operation] [Note: You may also include reference to 24-hour lines here.] [Note: If you have different numbers for accepting standard and expedited grievances, include both numbers here.]*

Method	Complaints about Part D prescription drugs – Contact Information
TTY	*[Insert number]* [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. *[Insert days and hours of operation] [Note: If you have different TTY numbers for accepting standard and expedited grievances, include both numbers here.]*
FAX	*[Optional: insert fax number] [Note: If you have different fax numbers for accepting standard and expedited grievances, include both numbers here.]*
WRITE	*[Insert address] [Note: If you have different addresses for accepting standard and expedited grievances, include both addresses here.]* *[**Note**: plans may add email addresses here.]*
MEDICARE WEBSITE	You can submit a complaint about *[insert 2021 plan name]* directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for medical care [*insert if applicable:* **or a drug**] you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see [*insert as applicable:* Chapter 5 *OR* Chapter 7] (*Asking us to pay our share of a bill you have received for covered medical services* [*insert if applicable: 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 [*insert as applicable:* Chapter 7 *OR* Chapter 9] *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for more information.

[Plans with different addresses and/or numbers for Part C and Part D claims may modify the table below or add a second table as needed.]

Method	Payment Requests– Contact Information
CALL	*[Optional: Insert phone number and days and hours of operation] [Note: You are required to accept payment requests in writing, and may choose to also accept payment requests by phone.]* Calls to this number are [*insert if applicable: not*] free.

Method	Payment Requests– Contact Information
TTY	*[Optional: Insert number] [Note: You are required to accept payment requests in writing, and may choose to also accept payment requests by phone.]* [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. *[Insert days and hours of operation]*
FAX	*[Optional: Insert fax number] [Note: You are required to accept payment requests in writing, and may choose to also accept payment requests by fax.]*
WRITE	*[Insert address]* *[**Note**: plans may add email addresses here.]*
WEBSITE	*[Insert URL]*

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 Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
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.

Method	Medicare – Contact Information
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. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about *[insert 2021 plan name]*: • **Tell Medicare about your complaint:** You can submit a complaint about *[insert 2021 plan name]* directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. 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 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. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (Free help, information, and answers to your questions about Medicare)

[Organizations offering plans in multiple states: Revise the second and third paragraphs in this section to use the generic name ("State Health Insurance Assistance Program" or "SHIP"), 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 information for 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. *[Multiple-state plans inserting information in an exhibit, replace rest of this paragraph with a sentence referencing the exhibit where members will find SHIP information.]* [*Multiple-state plans inserting information in the EOC add:* Here is a list of the State Health Insurance Assistance Programs in each state we serve:] *[Multiple-state plans inserting information in the EOC use bullets for the following sentence, inserting separate bullets for each state.]* In *[insert state]*, the SHIP 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.

Method	**[*Insert state-specific SHIP name]* *[If the SHIP's name does not include the name of the state, add:* ***([insert state name]* SHIP)***]– Contact Information**
CALL	*[Insert phone number(s)]*
TTY	*[Insert number, if available. Or delete this row.]* [*Insert if the SHIP uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]
WRITE	*[Insert address]* *[**Note**: plans may add email addresses here.]*
WEBSITE	*[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 the second and third paragraphs of 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 designated Quality Improvement Organization for serving Medicare beneficiaries in each state. *[Multi-state plans inserting information in an exhibit, replace rest of this paragraph with a sentence referencing the exhibit where members will find QIO information.]* [*Multiple-state plans inserting information in the EOC add:* Here is a list of the Quality Improvement Organizations in each state we serve:] *[Multi-state plans inserting information in the EOC use bullets for the following sentence, inserting separate bullets for each state.]* For *[insert state]*, the Quality Improvement Organization is called *[insert state-specific QIO name]*.

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

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

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

Method	***[Insert state-specific QIO name]*** [*If the QIO's name does not include the name of the state, add:* **(*[insert state name]*'s Quality Improvement Organization)**]**– Contact Information**
CALL	*[Insert phone number(s) and days and hours of operation]*
TTY	*[Insert number, if available. Or delete this row.]* [*Insert if the QIO uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]
WRITE	*[Insert address]* *[**Note**: plans may add email addresses here.]*
WEBSITE	*[Insert URL]*

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security

handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

[MA-only plans, omit] Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	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, days and hours of operation, 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.]

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.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact *[insert state-specific Medicaid agency]*.

Method	***[Insert state-specific Medicaid agency]*** [*If the agency's name does not include the name of the state, add:* **(*[insert state name]*'s Medicaid program)**]**– Contact Information**
CALL	*[Insert phone number(s) and days and hours of operation]*
TTY	*[Insert number, if available. Or delete this row.]* [*Insert if the state Medicaid program uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]
WRITE	*[Insert address]* *[**Note**: plans may add email addresses here.]*
WEBSITE	*[Insert URL]*

SECTION 7 Information about programs to help people pay for their prescription drugs

[Note: MA-only plans may delete this section.]

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."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing 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 copayment level, or, if you already have the evidence, to provide this evidence to us.

- *[Note: Insert plan's process for allowing members 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 (phone numbers are printed on the back cover of this booklet).

[*Plans in U.S. Territories, replace the Extra Help section with the following language if the EOC is used for plans only in the U.S. Territories. Add the following language to the Extra Help section if the EOC is used for plans in the U.S Territories and mainland regions:* There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about

their rules (phone numbers are in Section 6 of this chapter). Or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov or more information.]

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not receiving "Extra Help." For brand name drugs, the 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Part D Explanation of Benefits (Part D EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 75% of the price for generic drugs and you pay the remaining 25% of the price. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

[*Insert if the plan offers additional coverage in the gap:* The Medicare Coverage Gap Discount Program is available nationwide. Because *[insert 2021 plan name]* offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 6, Section 6 for more information about your coverage during the Coverage Gap Stage.]

[*Insert if the plan does not have a coverage gap:* The Medicare Coverage Gap Discount Program is available nationwide. Because *[insert 2021 plan name]* does not have a coverage gap, the discounts described here do not apply to you.

Instead, the plan continues to cover your drugs at your regular cost-sharing amount until you qualify for the Catastrophic Coverage Stage. Please go to Chapter 6, Section 5 for more information about your coverage during the Initial Coverage Stage.] If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

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

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance *[insert State-specific ADAP information]*. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. *[Insert State-specific ADAP contact information.]*

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call *[insert State-specific ADAP contact information]*.

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn't appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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.]

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

[Multiple-state plans inserting information in an exhibit, replace rest of this paragraph with a sentence referencing the exhibit where members will find SPAP information.] [*Multiple-state plans inserting information in the EOC add:* Here is a list of the State Pharmaceutical Assistance Programs in each state we serve:] *[Multi-state plans inserting information in the EOC use bullets for the following sentence, inserting separate bullets for each state.]* In *[insert state name]*, the State Pharmaceutical Assistance Program is *[insert state-specific SPAP name]*.

Method	***[Insert state-specific SPAP name]*** [*If the SPAP's name does not include the name of the state, add:* **(*[insert state name]*'s State Pharmaceutical Assistance Program)**] **– Contact Information**
CALL	*[Insert phone number(s) and days and hours of operation]*
TTY	*[Insert number, if available. Or delete this row.]* [*Insert if the SPAP uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]
WRITE	*[Insert address]* *[**Note**: plans may add email addresses here.]*
WEBSITE	*[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.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and 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	rrb.gov/

SECTION 9 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may 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. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

[Plans without Part D coverage delete this paragraph] 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

Chapter 3. Using the plan's coverage for your medical services

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SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care coverage. 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 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*).

Section 1.1 What are [*for partial or full network PFFS insert:* **"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 licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- [*Partial or full network PFFS plans insert:* **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services. Section 1.2 describes the rules for getting covered services using our network providers.]
- "**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.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, *[insert 2021 plan name]* must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

[Insert 2021 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.** "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You receive your care from a provider in the United States who (1) agrees to accept our plan's terms and conditions of payment prior to providing services to you and (2) is eligible to provide services under Original Medicare** [*Insert if applicable:* or eligible to be paid by *[insert 2021 plan name]* for benefits that are not covered under Original Medicare].
    - [*For non-network PFFS plans:* A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement (Medigap) plan. Your provider is not required to agree to accept the plan's terms and conditions of payment, and thus may choose not to treat you, with the exception of emergencies. If your provider does not agree to accept our terms and conditions of payment, they may choose not to provide health care services to you, except in emergencies. If this happens, you will need to find another provider who will accept our terms and conditions of payment. Providers can find the plan's terms and conditions of payment on our website at: *[insert link to PFFS terms and conditions of payment.]*]
    - [*For full and partial network PFFS plans:* A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement (Medigap) plan. We have network providers (that is, providers who have agreements with our plan) for [*full network PFFS plan insert:* all services covered under Original Medicare] *[partial network PFFS plans should indicate the category or categories of services for which network providers are available]*. These providers have already agreed to see members of our plan. If your provider is not one of our network providers, then the provider is not required to accept the plan's terms and conditions of payment and they may choose not to provide health care services to you, except in emergencies. If this happens, you will need to find another provider who will accept our terms and conditions of payment. Providers can find the plan's terms and conditions of payment on our website at: *[insert link to PFFS terms and conditions of payment]*.]
    - A provider is considered to have agreed to accept the terms and conditions of payment if the provider was aware that you are a member of *[insert 2021 plan name]* before providing services to you (for example: if you showed them your plan membership card); the provider had reasonable access to our terms and conditions of payment; and the provider provided covered services to you. The provider doesn't have to actually read the terms and conditions of payment – If the provider had the opportunity to read them and treats you, the law deems this provider to have agreed to accept our plan's terms and conditions of payment for that specific visit.
        - You must show your plan membership card every time you visit a provider. A provider can decide at every visit whether to accept our plan's terms and conditions, and thus treat you. A provider cannot change his/her mind about accepting the terms and conditions of payment after providing services.
        - Not all providers accept our plan's terms and conditions of payment or agree to treat you. A provider who decides not to accept our plan's terms and conditions of payment should not provide services to you, except in emergencies. You may contact us at *[insert contact information that*

includes at least a phone number] for assistance locating another provider in your area who will accept our plan's terms and conditions of payment.

- If you need emergency care, it is covered whether a provider agrees to accept the plan's payment terms or not.
- [*Partial and full network PFFS plans insert:* Our plan has agreements with some providers to deliver covered services to members in our plan. These providers are our network providers. *[Indicate how members can get the list of network providers.]*]
- [*Full network PFFS plans insert:* We have network providers for all services covered under Original Medicare *[indicate if network providers are available for any non-Medicare covered services]*. You can still receive covered services from out-of-network providers (those who do not have an agreement with our plan), as long as those providers agree to accept our plan's terms and conditions of payment, as described earlier in this section.]
- [*Partial network PFFS plans insert:* We have network providers for *[indicate what category or categories of services for which network providers are available]*. You can still receive covered services from out-of-network providers (those who do not have an agreement with our plan), as long as those providers agree to accept our plan's terms and conditions of payment, as described earlier in this section. For services for which network providers are not available, you can receive covered services from any provider who agrees to accept our plan's terms and conditions of payment, as described earlier in this section.]
- *[Partial and full network PFFS plans should describe whether or not the plan has established any higher cost-sharing requirements if the member obtains a covered service from a deemed (out-of-network) provider.]* [*Insert the following sentence if the plan includes such differential cost-sharing:* The amount of cost-sharing you pay a provider who is not one of our network providers may be more than the cost-sharing you pay a network provider. In the plan's Medical Benefits Chart in Chapter 4 of this booklet, we indicate the services for which the cost-sharing amount differs between network providers and out-of-network providers.]

- **You are required to pay only the copayment or coinsurance amount allowed by our plan at the time of the visit.** You should ask the provider to bill the plan for your covered services. If a provider asks you to pay the full amount of the services then send the bill or a copy of the bill to us to pay you back, remind the provider that you are only responsible for the cost-sharing amount. If the provider wants further information on payment for covered services, please have the provider contact us at *[Note: insert instructions that include a phone number and mailing address]*.
- [*Full and partial network PFFS plans insert:* Our plan will pay for all services that you receive from a network provider (including services you receive from an out-of-network provider when you are directed to see that provider by the plan or a network provider). If you decide to see an out-of-network provider who accepts our plan's terms and conditions of payment on your own, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan. [*Insert as applicable:* Chapter 7 *OR* Chapter 9] 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.]

- [*Non-network PFFS plans insert:* If you receive a service from a provider who accepts our plan's terms and conditions of payment, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan. [*Insert as applicable:* Chapter 7 *OR* Chapter 9] 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.]
- *[Insert 2021 plan name]* does not require members or their providers to obtain prior authorization or a referral from the plan as a condition for covering medically necessary services that are covered by our plan. Under prior authorization, a plan requires members or providers to seek authorization from the plan prior to obtaining services. There is no such requirement for our members. 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.

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

[Non-network PFFS plans can exclude this section.]

Section 2.1 How to get care from network providers

[Plans should describe how members access specialists and other network providers.]

What if a network provider leaves our plan?

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider to manage your care.

[Plans should provide contact information for assistance.]

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

Section 3.1 Getting care if you have a medical emergency

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

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

A "medical emergency" is when you believe that you have an injury or illness that requires immediate medical attention to prevent a disability or death. 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 or hospital. Call for an ambulance if you need it. You do *not* need to get approval from our plan.
- [*Plans add if applicable:* **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 provide either the phone number and days and hours of operation 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 or its territories *[plans may modify this sentence to identify whether this coverage is within the U.S. or world-wide emergency/urgent coverage]*. 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 world-wide emergency/urgent coverage or ambulance services outside of the U.S. and its territories, 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.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. If you decide to get follow-up care from the provider treating you, then you should advise them of your coverage as soon as possible, by showing them your plan membership card. The plan will pay for all medically-necessary plan-covered services furnished by the provider and non-emergency care that you get from any provider in the United States who agrees to accept our plan's terms and conditions of payment and is eligible to provide services under Original Medicare.

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.

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. [*Network or partial network PFFS plans add the following*: Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.] The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What providers should you use when you have an urgent need for care?

[*Network or partial network PFFS plans insert:* We cover urgently needed services you receive from a network provider or from any out-of-network provider who is willing to furnish services as a deemed provider.]

[*Non-network PFFS plans insert:* We will cover urgently needed services from any provider who is willing to furnish services as a deemed provider.]

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

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: *[insert website]* for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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

Section 4.1 You can ask us to pay our share of the cost of covered 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 [*insert as applicable:* Chapter 5 *OR* Chapter 7] (*Asking us to pay our share of a bill you have received for covered medical services [insert if applicable: or drugs]*) for information about what to do.

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

[Insert 2021 plan name] covers all medical services that are medically necessary, these services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan.

[*Full and partial network PFFS plans insert:* Our plan will pay for all services that you receive from a network provider (including services you receive from an out-of-network provider when you are directed to see that provider by the plan or a network provider). If you decide to see an out-of-network provider who accepts our plan's terms and conditions of payment on your own, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan.]

[*Non-network PFFS plans insert:* If you receive a service from a provider who accepts our plan's terms and conditions of payment, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan.]

If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

[*Insert as applicable:* Chapter 7 *OR* Chapter 9] (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* 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 to get more information (phone numbers are printed on the back cover of this booklet).

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 Member 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"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") 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 [*plans that conduct or cover clinical trials that are not approved by Medicare insert:* or our plan] first needs to approve the research study. If you participate in a study that Medicare [*plans that conduct or cover clinical trials that are not approved by Medicare insert:* or our plan] has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Once Medicare [*plans that conduct or cover clinical trials that are not approved by Medicare insert:* or our plan] 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 most of the costs 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 us *[plans that do not use PCPs may delete the rest of this sentence]* or your PCP. *[Non-network PFFS plans: Omit the following sentence]* 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.** If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- 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.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

> *Here's an example of how the cost-sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you

owe. Please see [*insert as applicable:* Chapter 5 *OR* Chapter 7] for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will 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 medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (www.medicare.gov). 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 covered in a "religious non-medical health care institution"

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. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 Receiving Care From a Religious Non-Medical Health Care Institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are 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 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.]

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

[Plans that allow transfer of ownership of certain DME items to members must modify this section to explain the conditions under which and when the member can own specified DME.]

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of *[insert 2021 plan name]*, however, you [*insert if the plan sometimes allows ownership:* usually] will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. [*Insert if your plan sometimes allows transfer of ownership for items other than prosthetics*: Under certain limited circumstances we will transfer ownership of the DME item to you. Call Member Services (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.] [*Insert if your plan never transfers ownership (except as noted above, for example, for prosthetics):* Even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.]

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments for the item under Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, *[insert 2021 plan name]* will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave *[insert 2021 plan name]* or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost-sharing? Will it change after 36 months?

[Plans should insert cost-sharing] Your cost sharing for Medicare oxygen equipment coverage is *[Insert copay amount or coinsurance percentage],* every *[Insert required frequency of payment].*

[Plans that use a constant cost-sharing structure insert] Your cost-sharing will not change after being enrolled for 36 months in *[insert 2021 plan name]*.

[Plans that wish to vary cost-sharing after 36 months insert details including whether original cost-sharing resumes after 5 years and you are still in the plan.]

If prior to enrolling in *[insert 2021 plan name]* you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in *[insert 2021 plan name]* is *[Plans should insert cost-sharing]*.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining *[insert 2021 plan name]*, join *[insert 2021 plan name]* for 12 months, and then return to Original Medicare, you will pay full cost-sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in *[insert 2021 plan name]* and then return to Original Medicare, you will pay full cost-sharing for oxygen equipment coverage.

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of *[insert 2021 plan name]*. Later in this chapter, you can find information about medical services that are not covered. [*Insert if applicable:* It also explains limits on certain services.] *[If applicable, you may mention other places where benefits, limitations, and exclusions are described, such as optional additional benefits, or addenda.]*

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

[Describe all applicable types of cost-sharing 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"** is the amount you must pay for medical services before our plan begins to pay its share. [*Insert if applicable:* (Section 1.2 tells you more about your plan deductible.)] [*Insert if applicable:* (Section 1.3 tells you more about your deductibles for certain categories of services.)]
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)
- *[Plans that allow providers to balance bill in their Terms & Conditions of payment may edit the percentage to reflect their actual balance billing rate.]* **"Balance billing"** is when providers, such as doctors or hospitals, charge and bill patients up to 15% more than the plan's payment amount for services. The "balance billing" amount is collected in addition to the patient's regular plan cost-sharing amount. [*Plans that prohibit balance billing insert: [Insert 2021 plan name]* does not allow providers who provide plan-covered services to balance bill members of our plan.] (For more information, see Section 1.6 of this chapter.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Member Services.

Section 1.2 What is your plan deductible?

[Plans with no deductibles, delete this section and renumber remaining subsections in Section 1.]

[Note: deductibles cannot be applied to $0.00 Medicare preventive services, emergency services or urgently needed services]

[Plans with separate in-network and out-of-network deductibles should revise this section (including the section title) as needed to describe the deductibles.]

Your deductible is *[insert deductible amount]*. This is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services. Until you have paid the deductible amount, you must pay the full cost of your covered services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share [*insert as applicable:* (your copayment) *OR* (your coinsurance amount) *OR* (your copayment or coinsurance amount)] for the rest of the calendar year.

[Plans may revise the paragraph to describe the services that are subject to the deductible.] The deductible does not apply to some services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible does not apply to the following services:

- *[Insert services not subject to the deductible.]*

Section 1.3 Our plan [*insert if plan has an overall deductible described in Section 1.2:* **also**] **has a** [*insert if plan has an overall deductible described in Section 1.2:* **separate**] **deductible for certain types of services**

[Plans with service category deductibles: insert this section. If applicable, plans may revise the text as needed to describe how the service category deductible(s) work with the overall plan deductible.]

[Plans with a service category deductible that is not based on the calendar year – e.g., a per-stay deductible – should revise this section as needed.]

[*Insert if plan has an overall deductible described in Section 1.2:* In addition to the plan deductible that applies to all of your covered medical services, we also have a deductible for certain types of services.]

[*Insert if plan does not have an overall deductible and Section 1.2 was therefore omitted:* We have a deductible for certain types of services.]

[*Insert if plan has one service category deductible:* The plan has a deductible amount of *[insert service category deductible]* for *[insert service category]*. Until you have paid the deductible amount, you must pay the full cost for *[insert service category]*. Once you have paid your deductible, we will pay our share of the costs for these services and you will pay your share ([*insert as applicable:* your copayment *OR* your coinsurance amount *OR* your copayment or coinsurance amount]) for the rest of the calendar year.] [*Insert if applicable:* Both the plan deductible and the deductible for *[insert service category]* apply to your covered *[insert service category]*. This means that once you meet *either* the plan deductible *or* the deductible for *[insert service category]*, we will begin to pay our share of the costs of your covered *[insert service category]*.]

[*Insert if plan has more than one service category deductible:* The plan has a deductible amount for the following types of services:

- [*Plans should insert a separate bullet for each service category deductible:* Our deductible amount for *[insert service category]* is *[insert service category deductible]*. Until you have paid the deductible amount, you must pay the full cost for *[insert service category]*. Once you have paid your deductible, we will pay our share of the costs for these services and you will pay your share ([*insert as applicable:* your copayment *OR* your coinsurance amount *OR* your copayment or coinsurance amount]) for the rest of the calendar year. [*Insert if applicable:* Both the plan deductible and the deductible for *[insert service category]* apply to your covered *[insert service category]*. This means that once you meet *either* the plan deductible *or* the deductible for *[insert service category]*, we will begin to pay our share of the costs of your covered *[insert service category]*.]]]

Section 1.4 What is the most you will pay for [*insert if applicable:* Medicare Part A and Part B] covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for medical services that are covered [*insert as applicable:* under Medicare Part A and Part B *OR* by our plan] (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of *[insert 2021 plan name]*, the most you will have to pay out-of-pocket for covered [*insert if applicable:* Part A and Part B] services in 2021 is *[insert MOOP]*. The amounts you pay for [*insert applicable terms:* deductibles, copayments, and coinsurance] for covered services count toward this maximum out-of-pocket amount. *[Plans with no premium and/or that do not offer Part D may modify the following sentence as needed.]* (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. [*Insert if applicable, revising reference to asterisk as needed:* In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.]) If you reach the maximum out-of-pocket amount of *[insert MOOP]*, you will not have to pay any out-of-pocket costs for the rest of the year for covered [*insert if applicable:* Part A and Part B]

services. However, you must continue to pay [*insert if plan has a premium:* your plan premium and] the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.5 Our plan also limits your out-of-pocket costs for certain types of services

[Plans with service category OOP maximums: insert this section.]

[Plans with a service category OOP maximum that is not based on the calendar year – e.g., a per-stay maximum – should revise this section as needed.]

In addition to the maximum out-of-pocket amount for covered [*insert as applicable:* Part A and Part B] services (see Section 1.4 above), we also have a separate maximum out-of-pocket amount that applies only to certain types of services.

[*Insert if plan has one service category MOOP:* The plan has a maximum out-of-pocket amount of *[insert service category MOOP]* for *[insert service category]*. Once you have paid *[insert service category MOOP]* out-of-pocket for *[insert service category]*, the plan will cover these services at no cost to you for the rest of the calendar year.] [*Insert if service category is included in MOOP described in Section 1.4:* Both the maximum out-of-pocket amount for [*insert as applicable:* Part A and Part B *OR* all covered] medical services and the maximum out-of-pocket amount for *[insert service category]* apply to your covered *[insert service category]*. This means that once you have paid *either [insert MOOP]* for [*insert as applicable:* Part A and Part B *OR* all covered] medical services *or [insert service category OOP max]* for your *[insert service category]*, the plan will cover your *[insert service category]* at no cost to you for the rest of the year.]

[*Insert if plan has more than one service category MOOP:* The plan has a maximum out-of-pocket amount for the following types of services:

- [*Plans should insert a separate bullet for each service category MOOP:* Our maximum out-of-pocket amount for *[insert service category]* is *[insert service category MOOP]*. Once you have paid *[insert service category MOOP]* out-of-pocket for *[insert service category]*, the plan will cover these services at no cost to you for the rest of the calendar year.] [*Insert if service category is included in MOOP described in Section 1.4:* Both the maximum out-of-pocket amount for [*insert as applicable:* Part A and Part B *OR* all covered] medical services and the maximum out-of-pocket amount for *[insert service category]* apply to your covered *[insert service category]*. This means that once you have paid *either [insert MOOP]* for [*insert as applicable:* Part A and Part B *OR* all covered] medical services *or [insert service category OOP max]* for your *[insert service category]*, the plan will cover your *[insert service category]* at no cost to you for the rest of the year.]]

Section 1.6 How does "balance billing" affect your costs?

[Note to plans: this section is in reference to balance billing allowed under 42 CFR 422.216(b)(1).]

[*Insert this paragraph if plan prohibits balance billing:* Our plan does not allow "balance billing." This means a provider is allowed to collect only the plan cost-sharing amounts from you and is not allowed to charge or bill you more for services. Balance billing is prohibited by providers who provide plan-covered services to *[insert 2021 plan name]* members.]

[*Insert this paragraph if plan allows balance billing:* In addition to collecting the plan cost-sharing amounts from *[insert 2021 plan name]* members, providers may "balance bill" members up to *[insert balance billing amount of 15 or less]*% of the total plan payment amount for services. *[If balance billing is allowed only for certain services, indicate so and list those services.]* Note: If you are enrolled in a state Medicaid program and held harmless from Medicare cost-sharing, *[insert 2021 plan name]* does not allow a provider to balance bill you.]

[*Insert this paragraph if the plan allows hospitals to balance bill:* Hospitals that want to balance bill must give you a notice before providing any hospital services for which your balance billing amount could be greater than $500. The notice must include the following information:

1. A notice that balance billing is permitted for those services;

2. A good faith estimate of the likely amount of balance billing based on your condition;

3. And, the amount of any deductible, coinsurance, and copayment that you may have to pay in addition to the balance billing amount.]

[*Insert if applicable*: Providers must also give you a notice of your estimated cost-sharing amount for the following services: *[describe type(s) of service and cost-sharing threshold for providing a notice]*.]

There is an additional type of balance billing that physicians who do not participate with Medicare and who are not in the plan's network have a right to collect. However, you will never have to pay this type of balance billing. The provider will collect this balance billing amount from us and you will only pay your cost-sharing amount. If you have any questions about how much you would have to pay a provider, please contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

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 2021 plan name]* covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are provided to our members.
- [*Insert as applicable:* We may also charge you "administrative fees" for missed appointments or for not paying your required cost-sharing at the time of service. Call Member Services if you have questions regarding these administrative fees. (Phone numbers for Member Services are printed on the back cover of this booklet.)]

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2021* Handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. [*Insert as applicable:* However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.]

- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2021, either Medicare or our plan will cover those services.

[*Insert if offering MA Uniformity Flexibility benefits and/or targeted supplemental benefits:* Important Benefit Information for Enrollees with Certain Chronic Conditions

- If you are diagnosed by a plan provider with the following chronic condition(s) identified below and meet certain medical criteria, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing:
  - *[List all applicable chronic conditions here.]*
  -
- Please go to the "Help with Certain Chronic Conditions" row in the below Medical Benefits Chart for further detail.]

[Instructions to plans offering MA Uniformity Flexibility benefits:

- *Plans must deliver to each clinically-targeted enrollee a written summary of those benefits so that such enrollees are notified of the MA Uniformity Flexibility for which they are eligible.*
- *If applicable, plans must update the Medical Benefits Chart and include a supplemental benefits chart including a column that details the exact targeted reduced cost sharing amount for each specific service, and/or the additional supplemental benefits being offered. Specific services should include details as it relates to Part D benefits.]*

You will see this apple next to the preventive services in the benefits chart.

[Instructions on completing benefits chart:

- *When preparing this Benefits Chart, please refer to the instructions for completing the standardized ANOC and EOC.*
- *If using Medicare FFS amounts (e.g. Inpatient and SNF cost sharing) the plan must insert the 2020 Medicare amounts and must insert: "These are 2020 cost sharing amounts and may change for 2021. [insert plan name] will provide updated rates as soon as they are released." Member cost-sharing amounts may not be left blank.*
- *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.*
- *Optional supplemental benefits are not permitted within the chart; plans that would like to include information about optional supplemental benefits within the EOC may describe these benefits within Section 2.2.*
- *All partial and full network PFFS plans with differential cost-sharing for in and out-of-network services should clearly indicate for each service applicable the cost-sharing amount for network and out-of-network providers and facilities.*
- *Plans that have tiered cost-sharing of medical benefits based on contracted providers should clearly indicate for each service the cost-sharing for each tier, in addition to defining what each tier means and how it corresponds to the characters or footnotes indicating such in the provider directory (when one reads the provider directory, it is clear what the symbol or footnote means when reading this section of the EOC).*

- *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. Additional benefits should be placed alphabetically in the chart.*
- *Plans must describe any restrictive policies, limitations, or monetary limits that might impact a member's access to services within the chart.*
- *Plans may add references to the list of exclusions in Section 3.1 as appropriate.*
- *Plans must make it clear for members (in the sections where members cost sharing is shown) whether their hospital copays or coinsurance apply on the date of admission and/or on the date of discharge.]*

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. *[Also list any additional benefits offered.]*	*[List copays / coinsurance / deductible.]*

Services that are covered for you	**What you must pay** when you get these services
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 could endanger the person's health or if authorized by the plan • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required	*[List copays / coinsurance / deductible. Specify whether cost-sharing applies one-way or for round trips.]*
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
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 24 months 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.]*	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Services that are covered for you	**What you must pay** when you get these services
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's [*insert as appropriate:* referral *OR* order]. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. *[Also list any additional benefits offered.]*	*[List copays / coinsurance / deductible]*
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months). *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.

Services that are covered for you	**What you must pay** when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • [*If the plan only covers manual manipulation, insert:* We cover only] Manual manipulation of the spine to correct subluxation *[Also list any additional benefits offered.]*	*[List copays / coinsurance / deductible]*
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years 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 (120 months), but not within 48 months of a screening sigmoidoscopy *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. *[If applicable, list copayment and/or coinsurance charged for barium enema.]*

Services that are covered for you	**What you must pay** when you get these services
[Also list any additional benefits offered.] [Include row if applicable. If plan offers dental benefits as optional supplemental benefits, they should not be included in the chart. Plans may describe them in Section 2.2 instead.] **Dental services** In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: *[List any additional benefits offered, such as routine dental care.]*	*[List copays / coinsurance / deductible]*
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.

Services that are covered for you	**What you must pay** when you get these services
Diabetes self-management training, diabetic services and supplies *[Plans may put items listed under a single bullet in separate bullets if the plan charges different copays. However, all items in the bullets must be included.]* For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. *[Also list any additional benefits offered.]*	*[List copays / coinsurance / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see [*insert as applicable:* Chapter 10 *OR* Chapter 12] of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. [*Plans that do not limit the DME brands and manufacturers that you will cover insert:* We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. [*Insert as applicable*: We included a copy of our DME supplier directory in the envelope with this booklet.] The most recent list of suppliers is [*insert as applicable:* also] available on our website at *[insert URL]*.] [*Plans that limit the DME brands and manufacturers that you will cover insert:* With this *Evidence of Coverage* document, we sent you *[insert 2021 plan name]*'s list of DME. The list tells you the brands and manufacturers of DME that we will cover. [*Insert as applicable*: We included a copy of our DME supplier directory in the envelope with this booklet]. This most recent list of brands, manufacturers, and suppliers is also available on our website at *[insert URL]*. Generally, *[insert 2021 plan name]* covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to *[insert 2021 plan name]* and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.) If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see [*insert as applicable:* Chapter 7 *OR* Chapter 9], *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*)]	*[List copays / coinsurance / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. [*Plans with a network insert*: Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.] *[Include in-network benefits. Also identify whether this coverage is only covered within the U.S. as required or whether emergency care is also available as a supplemental benefit that provides world-wide emergency/urgent coverage.]*	*[List copays / coinsurance/. If applicable, explain that cost-sharing is waived if member admitted to hospital.]*
Health and wellness education programs *[These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management. Describe the nature of the programs here.* *If this benefit is not applicable, plans should delete this row.]*	*[List copays / coinsurance/ deductible]*
Hearing services Diagnostic hearing and balance evaluations performed by your [*insert as applicable:* PCP *OR* provider] to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. *[List any additional benefits offered, such as routine hearing exams, hearing aids, and evaluations for fitting hearing aids.]*	[*List copays / coinsurance / deductible*]

Services that are covered for you	**What you must pay** when you get these services
Help with Certain Chronic Conditions *[If the enrollee has been diagnosed by a plan provider with the certain chronic condition(s) identified and meets certain criteria, they may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing. The certain chronic conditions must be listed here. The benefits listed here must be approved in the bid. Describe the nature of the benefits here.* *If this benefit is not applicable, plans should delete this entire row.]*	*[List copays / coinsurance / deductible]*
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care *[If needed, plans may revise language related to the doctor certification requirement.]* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • 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 and social services • Medical equipment and supplies	*[List copays / coinsurance / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not *[insert 2021 plan name]*.

Services that are covered for you	**What you must pay** when you get these services
Hospice care (continued) For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, [*non-network PFFS plans, insert:* you pay the plan cost-sharing for deemed providers.] [*network PFFS plans insert:* your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for deemed providers.] For services that are covered by *[insert 2021 plan name]* but are not covered by Medicare Part A or B: *[insert 2021 plan name]* will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. [*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.]	*[Include information about cost-sharing for hospice consultation services if applicable.]*

Services that are covered for you	**What you must pay** when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules *[MA-only plans, delete]* We also cover some vaccines under our Part D prescription drug benefit. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. *[List days covered and any restrictions that apply.]* Covered services include but are not limited to: • 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 care 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 • Inpatient substance abuse services	*[List all cost-sharing (deductible, copayments/ coinsurance) and the period for which they will be charged. If cost-sharing is based on the Original Medicare or a plan-defined benefit period, include definition/ explanation of approved benefit period here.]* [*Plans that use per-admission deductible include:* A per-admission deductible is applied once during the defined benefit period.] *[In addition, if applicable, explain all other cost-sharing that is charged during a benefit period.]*

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) • 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 [*Partial or full network PFFS plans with contracts with transplant providers outside of the community insert:* Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If *[insert 2021 plan name]* provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, 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 must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used *[Modify as necessary if the plan begins coverage with an earlier pint.]* • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	[*If cost-sharing is **not** based on the Original Medicare or plan-defined benefit period, explain here when the cost-sharing will be applied. If it is charged on a per-admission basis, include as applicable:* A deductible and/or other cost-sharing is charged for each inpatient stay.] *[If inpatient cost-sharing varies based on hospital tier, enter that cost-sharing in the data entry fields.]*

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 inpatient mental health services provided in a psychiatric unit of a general hospital.]*	[*List all cost-sharing (deductible, copayments/ coinsurance) and the period for which they will be charged. If cost-sharing is based on the Original Medicare or a plan-defined benefit period, include definition/explanation of approved benefit period here. Plans that use per-admission deductible include:* A per-admission deductible is applied once during the defined benefit period. *[In addition, if applicable, explain all other cost-sharing that is charged during a benefit period.]* [*If cost-sharing is **not** based on the Original Medicare or plan-defined benefit period, explain here when the cost-sharing will be applied. If it is charged on a per-admission basis, include as applicable:* A deductible and/or other cost-sharing is charged for each inpatient stay.]]

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay *[Plans with no day limitations on a plan's hospital or SNF coverage may modify or delete this row as appropriate.]* If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include: • Physician services • Diagnostic tests (like 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 / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when [*insert as appropriate:* referred *OR* ordered] by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's [*insert as appropriate:* referral *OR* order]. A physician must prescribe these services and renew their [*insert as appropriate:* referral *OR* order] yearly if your treatment is needed into the next calendar year. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs *[MA plans that will be or expect to use Part B step therapy should include the Part B drug categories below that may or will be subject to Part B step therapy as well as a link to a list of drugs that will be subject to Part B step therapy. The link may be updated throughout the year and any changes need to be added at least 30 days prior to implementation per 42 CFR 42.111(d)]* 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 or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were 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 erythropoiesis-stimulating agents *[plans may delete any of the following drugs that are not covered under the plan]* (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases [*insert if applicable:* The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: *insert link*] *[MA-only plans delete the following paragraphs]* We also cover some vaccines under our Part B and Part D prescription drug benefit. 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 explained in Chapter 6.	*[List copays / coinsurance / deductible]* *[Indicate whether drugs may be subject to step therapy]*

Services that are covered for you	**What you must pay** when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid Treatment Program Services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing *[Plans can include other covered items and services as appropriate (not to include meals and transportation).]*	*[List copays / coinsurance / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies *[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 • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • 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 must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. 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.]* • Other outpatient diagnostic tests *[Plans can include other covered tests as appropriate.]*	*[List copays / coinsurance / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Outpatient Hospital Observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	*[List copays / coinsurance / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. *[Also list any additional benefits offered.]*	*[List copays / coinsurance / deductible]*
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or 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. *[Also list any additional benefits offered.]*	*[List copays / coinsurance / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	*[List copays / coinsurance / deductible]*
Outpatient substance abuse services *[Describe the plan's benefits for outpatient substance abuse services.]*	*[List copays / coinsurance / deductible]*
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	*[List copays / coinsurance / deductible]*
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	*[List copays / coinsurance / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your [*insert as applicable:* PCP *OR* specialist], if your doctor orders it to see if you need medical treatment • [*Insert if providing any MA additional telehealth benefits consistent with 42 CFR § 422.135 in the plan's CMS-approved Plan Benefit Package submission:* Certain additional telehealth services, including those for: *[insert specific Part B service(s) the plan has identified as clinically appropriate to furnish through electronic exchange when the provider is not in the same location as the enrollee]*. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. o *[List the available means of electronic exchange used for each Part B service offered as an MA additional telehealth benefit along with any other access instructions that may apply.]]* • Brief virtual check-ins • Remote evaluation of pre-recorded video and/or images sent to your doctor • Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient • Second opinion [*Insert if appropriate:* by another network provider] prior to surgery • 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 physician) *[Also list any additional benefits offered.]*	*[List copays / coinsurance / deductible]* *[If applicable, indicate whether there are different cost-sharing amounts for Part B service(s) furnished through an in-person visit and those furnished through electronic exchange as MA additional telehealth benefits.]*

Services that are covered for you	**What you must pay** when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical 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 / deductible]*
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	*[List copays / coinsurance / deductible]*
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and [*insert as appropriate:* a referral *OR* an order] for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. *[Also list any additional benefits offered.]*	*[List copays / coinsurance / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	**What you must pay** when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient 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) • Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	*[List copays / coinsurance / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see *[insert as applicable:* Chapter 10 *OR* 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 but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled 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 must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used *[Modify as necessary if the plan begins coverage with an earlier pint.]* • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services	*[List copays / coinsurance / deductible. 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
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits. *[Also list any additional benefits offered.]*	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. *[Also list any additional benefits offered.]*	*[List copays / coinsurance / deductible]*

Services that are covered for you	**What you must pay** when you get these services
Urgently needed services *[Full-network plans insert this row:]* Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. [*Plans with a network insert*: Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.] *[Include in-network benefits. Also identify whether this coverage is within the U.S. or as a supplemental world-wide emergency/urgent coverage.]*	*[List copays / coinsurance. Plans should include different copayments for contracted urgent care centers, if applicable]*

Services that are covered for you	**What you must pay** when you get these services
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered 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 (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) *[Also list any additional benefits offered, such as supplemental vision exams or glasses. If the additional vision benefits are optional supplemental benefits, they should not be included in the benefits chart; they should be described within Section 2.2.]*	*[List copays / coinsurance / deductible]*
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

Section 2.2 Extra "optional supplemental" benefits you can buy

[Include this section if you offer optional supplemental benefits in the plan and describe benefits below. 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 described in [*insert as applicable:* this section *OR* the enclosed insert] are subject to the same appeals process as any other benefits.

[Insert plan specific optional 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).]

Section 2.3 Getting care using our plan's optional visitor/traveler benefit

[Non-network PFFS plans exclude this section]

[*Full and Partial network PFFS plans: If your plan offers a visitor/traveler program to members who are out of your service area, insert this section, adapting and expanding the following paragraphs as needed to describe the visitor/traveler benefits and rules related to receiving the out-of-area coverage. The visitor/travel benefit applies to all the categories of services for which the plan has established a network of providers. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR 422.74(b)(4)(iii) (for more than six months up to 12 months) also explain that here based on the language suggested below.*

When you are continuously absent from our plan's service area for more than six months, we usually must disenroll you from our plan. However, we offer as a supplemental benefit a visitor/traveler program *[specify areas where the visitor/traveler program is being offered],* which will allow you to remain enrolled in our plan when you are outside of our service area for less than 12 months. This program is available to all *[insert 2021 plan name]* members who are temporarily in the visitor/traveler area. Under our visitor/traveler program, you may receive all plan-covered services at in-network cost-sharing. Please contact the plan for assistance in locating a provider when using the visitor/traveler benefit.

If you are in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you have not returned to the plan's service area within 12 months, you will be disenrolled from the plan.]

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists some services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service 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 [*insert as applicable:* Chapter 7 *OR* Chapter 9], Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

[The services listed in the chart below 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 add parenthetical references to the Benefits Chart for descriptions of covered services/items as appropriate. Plans may reorder the below excluded services alphabetically, if they wish. Plans may also add exclusions as needed.]

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.
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 is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings or dentures.	✓	
Non-routine dental care.		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
Home-delivered meals	✓	
Orthopedic shoes		✓ If 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		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine hearing exams, hearing aids, or exams to fit hearing aids.	✓	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Acupuncture		✓
Naturopath services (uses natural or alternative treatments).	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

[PFFS without Part D coverage: Omit this chapter]

CHAPTER 5

Using the plan's coverage for your Part D prescription drugs

Chapter 5. Using the plan's coverage for your Part D prescription drugs

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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* about the costs for Part D prescription drugs** [*insert as applicable:* **may** *OR* **does**] **not apply to you.** *[If not applicable, omit information about the LIS Rider]* We [*insert as appropriate:* have included *OR* sent you] a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider." (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 1 Introduction

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 2021 plan name]* also covers some drugs under the plan's medical benefits. Through its coverage of Medicare Part A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including 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 drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. Our plan only covers Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 *(What if you're in Medicare-certified hospice)*. For information on hospice coverage, see the hospice section of Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

The following sections discuss coverage of your drugs under the plan's Part D benefit rules. Section 9, *Part D drug coverage in special situations* includes more information on your Part D coverage and Original Medicare.

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:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy [insert if applicable: or through the plan's mail-order service]*.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy [*insert if applicable:* **or through the plan's mail-order service**]

Section 2.1 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. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-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 on the plan's Drug List.

[*Include if plan has pharmacies that offer preferred cost-sharing in its networks*: Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost-sharing may be less at pharmacies with preferred cost-sharing.]

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (*[insert URL]*), or call Member Services (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. [*Insert if plan has pharmacies that offer preferred cost-sharing in its network:* However, your costs may be even less for your covered drugs if you use a network pharmacy that offers preferred cost-sharing rather than a network pharmacy that offers standard cost-sharing. The *Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost-sharing. You can find out more about how your out-of-pocket costs could be different for different drugs by contacting us.] *[Plans in which members do not need to take any action to switch their prescriptions may delete the following sentence]* If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask [*insert if applicable:* either to have a new prescription written by a provider 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. [*Insert if applicable:* Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost-sharing, you may want to switch to a different pharmacy.] To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the *Pharmacy Directory*. [*Insert if applicable:* You can also find information on our website at *[insert website address]*.]

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy. *[Plans may insert additional information about home infusion pharmacy services in the plan's network.]*
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, 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 (not available in Puerto Rico). 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 drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3 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. Generally, the drugs provided through mail-order are drugs that you take on a regular basis, for a chronic or long-term medical condition.] [*Insert if plan marks mail-order drugs in formulary:* The drugs available through our plan's mail-order service are marked as "**mail-order" drugs** in our Drug List.] [*Insert if plan marks non-mail-order drugs in formulary:* The drugs that are *not* available through the plan's mail-order service are marked with an asterisk in our Drug List.]

Our plan's mail-order service [*insert either:* allows *OR* 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** *OR* **a [XX]-day supply**].

[Plans that offer mail-order benefits with both preferred and standard cost-sharing may add language to describe both types of cost-sharing.]

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

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

[Sponsors should provide the appropriate information below from the following options, based on i) whether the sponsor is operating under the exception for new prescriptions described in the December 12, 2013 HPMS memo; and ii) whether the sponsor offers an optional automatic refill program. Sponsors who provide automatic delivery through retail or other non-mail-order means have the option to either add or replace the word "ship" with "deliver" as appropriate.]

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

[***Option 1:*** *Plan Sponsors operating under the auto-ship policy as described in the 2014 Final Call Letter (all new prescriptions from provider offices must be verified with the member before filled), insert the following:*

New prescriptions the pharmacy receives directly from your doctor's office.
After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.]

[***Option 2:*** *Plan Sponsors operating under the exception to the auto-ship policy, as described in the December 12, 2013 HPMS memo (new prescriptions received directly from provider offices can be filled without member verification when conditions are met), insert the following:*

New prescriptions the pharmacy receives directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

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

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

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

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health

care provider's office, please contact us by *[insert instructions]*.]

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

[***Option 1:*** *Sponsors that* ***do not*** *offer a program that automatically processes refills, insert the following:*

Refills on mail-order prescriptions. For refills, please contact your pharmacy *[insert recommended number of days]* days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.]

[***Option 2:*** *Sponsors that* ***do*** *offer a program that automatically processes refills, insert the following:*

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program [*optional: "*called *insert name of auto refill program"*]. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy *[insert recommended number of days]* days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

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

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

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. *[Insert instructions on how members should provide their communication preferences.]*]

Section 2.4 How can you get a long-term supply of drugs?

[Plans that do not offer extended-day supplies: Delete Section 2.4.]

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

condition.) [*Insert if applicable:* You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy]

1. *[Delete if plan does not offer extended-day supplies through retail pharmacies.]* **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. [*Insert if applicable:* Some of these retail pharmacies [*insert if applicable:* (which offer preferred cost-sharing)] [*insert if applicable:* may] agree to accept the [*insert as appropriate:* lower *OR* mail-order] cost-sharing amount for a long-term supply of maintenance drugs.] [*Insert if applicable:* Other retail pharmacies may not agree to accept [*insert as appropriate:* a lower *OR* the mail-order] cost-sharing amounts for a long-term supply of maintenance 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 long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

2. *[Delete if plan does not offer mail-order service.]* [*Insert as applicable:* For certain kinds of drugs, you *OR* You] can use the plan's network **mail-order services.** [*Insert if plan marks mail-order drugs in formulary, adapting as needed:* The drugs available through our plan's mail-order service are marked as "**mail-order" drugs** in our Drug List.] [*Insert if plan marks non-mail-order drugs in formulary, adapting as needed:* The drugs that are *not* available through the plan's mail-order service are marked with an asterisk in our Drug List.] Our plan's mail-order service [*insert either:* allows *OR* 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 *OR* a [XX]-day supply.**] See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. [*Insert if applicable:* To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.] If you cannot 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. (Phone numbers for Member Services are printed on the back cover of this

booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

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 your normal share of the cost) at the time 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 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 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.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

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 use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- Approved by the Food and Drug Administration (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.);
- -- *or* -- Supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; Lexi-Drugs; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

[Plans that are not offering indication based formulary design should delete this section]
Certain drugs may be covered for some medical conditions, but are considered non-formulary for other medical conditions. Drugs that are covered for only select medical conditions will be identified on our Drug List and in Medicare Plan Finder, along with the specific medical conditions that they cover.

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. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

[*Insert if applicable:*

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Member Services (phone numbers are printed on the back cover of this booklet).]

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 about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are *[insert number of tiers]* "cost-sharing tiers" for drugs on the Drug List

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

Every drug on the plan's Drug List is in one of *[insert number of tiers]* cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

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

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have *[insert number]* ways to find out:

1. Check the most recent Drug List we [*insert*: sent you in the mail] OR [*insert*: provided electronically]. [*Insert if applicable:* (Please note: The Drug List we

provide includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Member Services to find out if we cover it.)]

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 printed on the back cover of this booklet.)

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

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 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 to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 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]

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. [*Insert as applicable:* **In most cases, when** OR **When**] **a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider [*insert as applicable:* has told us the medical reason that the generic drug will not work for you *OR* has written "No substitutions" on your prescription for a brand name drug *OR* has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will 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 provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." 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 less costly but just as 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 by limiting 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.

Section 4.3 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 printed on the back cover of this booklet) or check our website (*[insert URL]*).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. 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.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. *[Delete this sentence if plan does not have step therapy]* For example, 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 this sentence 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. In some cases, you may want us to waive the restriction for you.
- *[Omit if plan's formulary structure (e.g., no tiers) does not allow for tiering exceptions]* The drug is covered, but it is in a cost-sharing tier 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 tiers]* different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier 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 next sentence if plan's formulary structure (e.g., no tiers) does not allow for tiering exceptions]* 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 5.2 to learn what you can do.

- [*Omit if plan's formulary structure (e.g., no tiers) does not allow for tiering exceptions*] If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 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 the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

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 provider 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 **no longer on the plan's Drug List;**
  - or -- The drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

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

- *[Sponsors may omit this scenario if all current members will be transitioned in advance for the following year]* **For those members who are new or who were in the plan last year:**

  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 if you were new and during the first *[insert time period (must be at least 90 days)]* of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of *[insert supply limit (must be at least the number of days in the plan's one month supply)]*. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of *[insert supply limit (must be at least the number of days in the plan's one month supply)]* of medication. The prescription must be filled at a network pharmacy.

(Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who have been in the plan for more than *[insert time period (must be at least 90 days)]* and reside in a long-term care (LTC) facility and need a supply right away:**

  We will cover one *[insert supply limit (must be at least a 31-day supply)]* supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply transition.

- *[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 printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. 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 provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider 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 provider says that you have medical reasons that justify asking us for an exception, your provider 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 may omit the following paragraph if they do not have an advance transition process for current members.] 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 next year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 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 5.3 What can you do if your drug is in a cost-sharing tier you think is too high? *[Plans with a formulary structure (e.g., no tiers or defined standard coinsurance across all tiers) that does not allow for tiering exceptions: omit Section 5.3]*

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier 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 provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 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.

[*Insert if applicable:* Drugs in our *[insert name of specialty tier]* are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.]

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 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 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.
- *[Plans that do not use tiers may omit]* Move a drug to a higher or lower cost-sharing tier.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

[Plan sponsors that otherwise meet all requirements and want the option to immediately replace brand name drugs with their new generic equivalents should insert A. Advance General Notice and a specific clause identified in the section on Other changes to the Drug List below. Plan sponsors that will not be using the option to make immediate substitutions of new generic drugs should insert B. Information on generic substitutions below.]

[***A. Advance General Notice that plan sponsor may immediately substitute new generic drugs:*** *In order to immediately replace brand name drugs with new therapeutically equivalent generic drugs (or change the tiering or the restrictions, or both, applied to a brand name drug after adding a new generic drug), plan sponsors that otherwise meet the requirements must provide the following advance general notice of changes:*

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**

    - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic versions of the same drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the

brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both.

- We may not tell you in advance before we make that change—even if you are currently taking the brand name drug.
- You or your prescriber can ask us 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 (coverage decisions, appeals, complaints)).*
- If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.]

[*B. Information on generic substitutions for plan sponsors that will not be immediately substituting new generic drugs.* *Plan sponsors that will not be making any immediate substitutions of new generic drugs should insert the following:*

- **A generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
  - If a brand name drug you are taking is replaced by a generic drug, the plan must give you at least 30 days' advance notice of the change or give you notice of the change and a *[insert supply limit (must be at least the number of days in the plan's one month supply)]* -day refill of your brand name drug at a network pharmacy.
  - After you receive notice of the change, you should be working with your provider to switch to the generic or to a different drug that we cover.
  - Or you or your 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 (coverage decisions, appeals, complaints).*]

[All plan sponsors should include the remainder of this section, with applicable clause noted below.]

- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**

- We may make other changes once the year has started that affect drugs you are taking. For instance, *[plan sponsors that want the option to immediately substitute new generic drugs insert:* we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might*] OR [plan sponsors that will not be making immediate generic substitutions insert:* we might:*]* make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give you notice of the change and a *[insert supply limit (must be at least the number of days in the plan's one month supply)]*-day refill of the drug you are taking at a network pharmacy.
- After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
- Or you or your prescriber can ask us to make an exception and continue to cover the 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 (coverage decisions, appeals, complaints).*

Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

- *[Plans that do not use tiers, may omit]* If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), 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 probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the Drug List in the new benefit year for any changes to drugs.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

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 [*insert if applicable:* (except for certain excluded drugs covered under our enhanced 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 it 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 three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "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; Lexi-Drugs; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. 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 [*Insert if applicable:* (Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may be charged an additional premium. More information is provided below.)]:

- Non-prescription drugs (also called over-the-counter drugs)
- 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
- 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

[*Insert if applicable:* We offer additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). *[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" program will not pay for the drugs not normally covered. (Please refer to the plan's Drug List or call Member Services for more information. Phone numbers for Member Services are printed on the back cover of this booklet.) However, if you have drug coverage through Medicaid, 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. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)]

[*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. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)]

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 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.

Section 8.2 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 9 Part D drug coverage in special situations

Section 9.1 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 switch plans or change your coverage. (Chapter 10, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) 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 (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) 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 total supply will be for a maximum of *[insert supply limit (must be at least the number of days in a plan's one month supply)]*, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

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 provider 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 provider 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 provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

Section 9.3 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 that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription 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. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or

prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 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.
- Unsafe amounts of opioid pain medications

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

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

[Plans should include this section if they have a Drug Management Program.]

We have a program that can help make sure our members safely use their prescription opioid medications, and other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your

doctors, if we decide your use of prescription opioid [*insert if applicable:* or benzodiazepine] medications is not safe, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid [*insert if applicable:* or benzodiazepine] medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid [*insert if applicable:* or benzodiazepine] medications from a certain doctor(s)
- Limiting the amount of opioid [*insert if applicable:* or benzodiazepine] medications we will cover for you

If we think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug misuse or with the limitation, you and your prescriber have the right to ask us for an appeal. If you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) [*insert if plan has other medication management programs:* **and other**] program [*insert if applicable:* "**s**"] to help members manage their medications

We have a program *[delete "a" and insert "programs" if plan has other medication management programs]* that can help our members with complex health needs.

This program is [*if applicable replace with:* "These programs are"] voluntary and free to members. A team of pharmacists and doctors developed the program [*insert if applicable:* "s"] for us. This program [*insert if applicable*: "The programs"] can help make sure that our members get the most benefit from the drugs they take. Our [*if applicable replace with:* One] program is called a Medication Therapy Management (MTM) program.

Some members who take medications for different medical conditions and have high drug costs, or are in a Drug Management Program to help members use their opioids safely may be able to get services through a MTM program. A pharmacist or other health professional will give you a

comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

[PFFS without Part D coverage: Omit this chapter]

CHAPTER 6

What you pay for your Part D prescription drugs

Chapter 6. What you pay for your Part D prescription drugs

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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* about the costs for Part D prescription drugs** [*insert as applicable:* **may** *OR* **does**] **not apply to you.** *[If not applicable, omit information about the LIS Rider]* We [*insert as appropriate:* have included *OR* sent you] a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider." (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 1 Introduction

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, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. [*Optional for plans that provide supplemental coverage:* Some excluded drugs may be covered by our plan if you have purchased 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 tiers, omit]* It also tells which of the *[insert number of tiers]* "cost-sharing tiers" 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 printed on the back 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 *[insert if applicable:* ***Provider/]*** ***Pharmacy Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *[insert if applicable: Provider/] Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

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 amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

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

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

Section 2.1 What are the drug payment stages for *[insert 2021 plan name]* members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under *[insert 2021 plan name]*. 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. *[Plans with no premium delete the following sentence]* Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

[Plans: Ensure entire table appears on the same page.]

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
[*If plan has a deductible for all tiers insert:* You begin in this payment stage when you fill your first prescription of the year.] During this stage, **you pay the full cost** of your [*insert if applicable:* brand name *OR [tier name(s)]*] drugs. You stay in this stage until you have paid $ *[insert deductible amount]* for your [*insert if applicable:* brand name *OR [tier name(s)]*] drugs ($*[insert deductible amount]* is the amount of your [*insert if applicable:* brand name *OR [tier name(s)]*] deductible). (Details are in Section 4 of this chapter.) [*Plans with no deductible replace the text above with:* Because there is no deductible for the plan, this payment stage does not apply to you.]	[*Insert if plan has no deductible:* You begin in this stage when you fill your first prescription of the year.] [*Insert if plan has no deductible or a deductible that applies to all drugs:* During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**.] [*Insert if plan has a deductible that applies to some drugs:* During this stage, the plan pays its share of the cost of your [*insert if applicable:* generic *OR [tier name(s)]*] drugs and **you pay your share of the cost.** After you (or others on your behalf) have met your [*insert if applicable:* brand name *OR [tier name(s)]*] deductible, the plans pays its share of the costs of your [*insert if applicable:* brand name *OR [tier name(s)]*] drugs and you pay your share.] You stay in this stage until your year-to-date [*insert as applicable:* **"total drug costs"** (your payments plus any Part D plan's payments) total $*[insert initial coverage limit] OR* **"out-of-pocket costs"** (your payments) reach $ *[insert 2021 out-of-pocket threshold].*] (Details are in Section 5 of this chapter.)	[*Plans with no additional gap coverage insert:* During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs.] [*Plans with additional generic coverage only in the gap insert:* For generic drugs, you pay *[plans should briefly describe generic coverage (e.g., either a $10 copayment or 25% of the costs, whichever is lower)].* For brand name drugs, you pay 25% of the price (plus a portion of the dispensing fee).] *[Plans with some coverage in the gap: insert description of gap coverage using standard terminology.]* You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach a total of $ *[insert 2021 out-of-pocket threshold]*. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.) [*Plans with no coverage gap replace the text above with:* Because there is no coverage gap for the plan, this payment stage does not apply to you.]	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2021). (Details are in Section 7 of this chapter.)

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

Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")

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 have paid. 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 or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the "Part D EOB") when you have had one or more prescriptions filled through the plan during the previous month. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower cost options. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf 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.
- **Drug price information.** This information will display cumulative percentage increases for each prescription claim.
- **Available lower cost alternative prescriptions.** This will include information about other drugs with lower cost-sharing for each prescription claim that may be available.

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 keep track of your out-of-pocket costs. 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, Section 2 of this booklet.) Here are some types of situations when you may want to give 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 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 under special circumstances.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by *[plans without an SPAP in their state delete next item]* a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Part D Explanation of Benefits* (a Part D EOB) 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 printed on the back cover of this booklet). *[Plans that allow members to manage this information on-line may describe that option here.]* Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Deductible Stage, you pay the full cost of your *[insert drug tiers if applicable]* drugs

Section 4.1 You stay in the Deductible Stage until you have paid *$[insert deductible amount]* for your *[insert drug tiers if applicable]* drugs

[*Plans with no deductible replace Section 4 title with:* There is no deductible for *[insert 2021 plan name]*.]

[*Plans with no deductible replace Section 4.1 title with:* You do not pay a deductible for your Part D drugs.]

[*Plans with no deductible replace text below with*: There is no deductible for *[insert 2021 plan name]*. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.]

The Deductible Stage is the first payment stage for your drug coverage. [*Plans with a deductible for all drug types/tiers, insert:* This stage begins when you fill your first prescription in the year. 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 2021.] [*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 tiers]* drugs. **You must pay the full cost of your *[insert applicable drug tiers]* 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 *[insert drug tiers if applicable]* drugs, you leave the 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

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

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your [*insert as applicable:* copayment *OR* coinsurance amount *OR* copayment or coinsurance amount]). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has *[insert number of tiers]* cost-sharing tiers

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

Every drug on the plan's Drug List is in one of *[insert number of tiers]* cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

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

To find out which cost-sharing tier 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:

- *[Plans retail network pharmacies that offer preferred cost-sharing, delete this bullet and use next two bullets instead]* A retail pharmacy that is in our plan's network
- [*Plans with retail network pharmacies that offer preferred cost-sharing, insert:* A network retail pharmacy that offers standard cost-sharing]
- [*Plans with retail network pharmacies that offer preferred cost-sharing, insert:* A network retail pharmacy that offers preferred cost-sharing]
- 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.*

[*Include if plan has network pharmacies that offer preferred cost-sharing:* Generally, we will cover your prescriptions *only* if they are filled at one of our network pharmacies. Some of our network pharmacies also offer preferred cost-sharing. You may go to either network pharmacies that offer preferred cost-sharing or other network pharmacies that offer standard cost-sharing to receive your covered prescription drugs. Your costs may be less at pharmacies that offer preferred cost-sharing.]

Section 5.2 A table that shows your costs for a *one-month* 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 Stage, 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 tiers, omit] As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- *[Plans without copayments, omit]* If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

[*If the plan has retail network pharmacies that offer preferred cost-sharing, the chart must include both standard and preferred cost-sharing rates. For plans that offer mail-order benefits with both preferred and standard cost-sharing, sponsors may at their option modify the chart to indicate the different rates. If any columns do not apply to the plan (e.g., preferred cost-sharing or mail order), remove them from the table. The plan may also add or remove tiers as necessary. If mail order is not available for certain tiers, plans should insert the following text in the cost-sharing cell:* Mail order is not available for drugs in *[insert tier]*.]

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	**Standard retail cost-sharing (in-network)** (up to a *[insert number of days]*-day supply)	**Preferred retail cost-sharing (in-network)** (up to a *[insert number of days]*-day supply)	**Mail-order cost-sharing** (up to a *[insert number of days]*-day supply)	**Long-term care (LTC) cost-sharing** (up to a *[insert number of days]*-day supply)	**Out-of-network cost-sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a *[insert number of days]*-day supply)
Cost-Sharing Tier 1 (*[insert description (e.g., generic drugs)]*)	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*
Cost-Sharing Tier 2 (*[insert description]*)	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*
Cost-Sharing Tier 3 (*[insert description]*)	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*
Cost-Sharing Tier 4 (*[insert description]*)	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
    - *[If the plan's one month's supply is not 30 days, edit the number of days in and the copay for a full month's supply. For example, if the plan's one-month supply is 28 days, revise the information in the next two bullets to reflect a 28-day supply of drugs and a $28 copay.]* Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4 A table that shows your costs for a *long-term* [*insert if applicable:* up to a] *[insert number of days]* –day supply of a drug

[Plans that do not offer extended-day supplies delete Section 5.4.]

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is [*insert if applicable:* up to] a *[insert number of days]*-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

The table below shows what you pay when you get a long-term ([*insert if applicable:* up to a] *[insert number of days]*-day) supply of a drug.

- *[Plans without copayments, omit]* Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

[*If the plan has retail network pharmacies that offer preferred cost-sharing, the chart must include both standard and preferred cost-sharing rates. For plans that offer mail-order benefits with both preferred and standard cost-sharing, sponsors may at their option modify the chart to indicate the different rates. If any columns do not apply to the plan (e.g., preferred cost-sharing or mail-order), remove them from the table. The plan may also add or remove tiers as necessary. If mail-order is not available for certain tiers, plans should insert the following text in the cost-sharing cell:* Mail-order is not available for drugs in *[insert tier]*.]

[*Plans must include all of their tiers in the table. If plans do not offer extended-day supplies for certain tiers, the plan should use the following text in the cost-sharing cell:* A long-term supply is not available for drugs in *[insert tier]*.]

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard retail cost-sharing (in-network) ([*insert if applicable:* up to a] *[insert number of days]*-day supply)	Preferred retail cost-sharing (in-network) ([*insert if applicable:* up to a] *[insert number of days]*-day supply)	Mail-order cost-sharing ([*insert if applicable:* up to a] *[insert number of days]*-day supply)
Cost-Sharing Tier 1 (*[insert description]*)	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*
Cost-Sharing Tier 2 (*[insert description]*)	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*
Cost-Sharing Tier 3 (*[insert description]*)	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*
Cost-Sharing Tier 4 (*[insert description]*)	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*	*[insert copay/ coinsurance]*

Section 5.5 You stay in the Initial Coverage Stage until your [*insert as applicable:* total drug costs for the year reach $*[insert initial coverage limit]* OR out-of-pocket costs for the year reach $ *[insert 2021 out-of-pocket threshold]*]

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 any Part D 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. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - *[Plans without a deductible, omit]* The $*[insert deductible amount]* you paid when you were in the Deductible Stage.

  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.

- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2021, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

[*Plans with no additional coverage gap replace the text above with:* You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $*[insert 2021 out-of-pocket threshold]*. Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. (See Section 5.5 for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of $*[insert 2021 out-of-pocket threshold]*, you leave the Initial Coverage Gap and move on to the Catastrophic 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 [*insert if plan has a coverage gap:* 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 *Part D Explanation of Benefits* (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent for your drugs during the year. Many people do not reach the *[insert as applicable: $[insert initial coverage limit] OR $ [insert 2021 out-of-pocket threshold]]* limit in a year.

We will let you know if you reach this *[insert as applicable: $[insert initial coverage limit] OR $[insert 2021 out-of-pocket threshold]]* amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the [*insert as applicable:* Coverage Gap Stage *OR* Catastrophic Coverage Stage.]

Section 5.6 How Medicare calculates your out-of-pocket costs for prescription drugs

[Plans with no coverage gap: insert Section 5.6]

[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 2021 out-of-pocket threshold]*, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

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 Deductible Stage.
  - The Initial Coverage Stage.
- Any payments you made during this calendar year as a member of a different 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, by AIDS drug assistance programs, *[plans without an SPAP in their state delete next item]* by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $***[insert 2021 out-of-pocket threshold]*** in out-of-pocket costs within the calendar year, you will move from the Initial Coverage 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 made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' 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 printed on the back cover of this booklet).

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

- **We will help you**. The *Part D Explanation of Benefits* (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $*[insert 2021 out-of-pocket threshold]* in out-of-pocket costs for the year, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.]

SECTION 6 During the Coverage Gap Stage, [*insert as appropriate:* you receive a discount on brand name drugs and pay no more than 25% of the costs of generic drugs *OR* the plan provides some drug coverage]

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $*[insert 2021 out-of-pocket threshold]*

[*Plans with no coverage gap replace Section 6 title with:* There is no coverage gap for *[insert 2021 plan name]*.]

[*Plans with no coverage gap replace Section 6.1 title with:* You do not have a coverage gap for your Part D drugs.]

[*Plans with no coverage gap replace text below with*: There is no coverage gap for *[insert 2021 plan name]*. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.]

[Plans with some coverage in the gap, revise the text below as needed to describe the plan's coverage.]

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 25% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2021, that amount is $*[insert 2021 out-of-pocket threshold]*.

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 2021 out-of-pocket threshold]*, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

[Plans with a coverage gap: insert Section 6.2]

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

These payments <u>are included</u> in your out-of-pocket costs

When you add up your out-of-pocket costs, **<u>you can include</u>** 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 Deductible Stage.
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any payments you made during this calendar year as a member of a different 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, by AIDS drug assistance programs, *[plans without an SPAP in their state delete next item]* by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $*[insert 2021 out-of-pocket threshold]* in out-of-pocket costs within the calendar year, you will move from the [*insert as applicable:* Initial Coverage Stage *OR* 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 made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' 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 printed on the back cover of this booklet).

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

- **We will help you**. The *Part D Explanation of Benefits* (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $*[insert 2021 out-of-pocket threshold]* in out-of-pocket costs for the year, this report will tell you that you have left the [*insert as applicable:* Initial Coverage Stage *OR* Coverage Gap Stage] and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 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

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 2021 out-of-pocket threshold]* 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 2021 catastrophic cost-sharing amount for generics/preferred multisource drugs]* for a generic drug or a drug that is treated like a generic and $*[insert 2021 catastrophic cost-sharing amount for all other drugs]* 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.]

[If plan provides coverage for excluded drugs as a supplemental benefit, insert a description of cost-sharing in the Catastrophic Coverage Stage.]

SECTION 8 Additional benefits information

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 covered by Part D depends on how and where you get them

Section 9.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

There are two parts to our coverage of Part D 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 vaccine**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D 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 (Formulary).*
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccine.**

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

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. 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 vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. [*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 Part D vaccine at the pharmacy and you get your vaccine at the network 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] for the vaccine and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D 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 us to pay our share of a bill you have received for covered medical services or drugs*).
- You will be reimbursed the amount you paid less your normal [*insert as appropriate:* 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 receive "Extra Help," we will reimburse you for this difference.)]

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

- You will have to pay the pharmacy the amount of your [*insert as appropriate:* coinsurance *OR* copayment] for the vaccine itself.
- When your doctor gives you the vaccine, 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 for administering 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.]

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 for Member Services are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- [*Full and partial network plans insert:* We can tell you how to keep your own cost down by using providers and pharmacies in our network.]
- [*Full and partial network plans:* 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.]

CHAPTER 7

Asking us to pay our share of a bill you have received for covered medical services [if applicable: or drugs]

Chapter 7. Asking us to pay our share of a bill you have received for covered medical services [*if applicable:* or drugs]

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SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services [*if applicable:* or drugs]

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

[Non-network PFFS plans may edit this section to remove network references as necessary.]

Sometimes when you get medical care or [*if applicable:* 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 [*if applicable:* 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 care from a provider who is not in our plan's network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency 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.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we

cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services [*insert if applicable:* or drugs] after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement. Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

[MA-only delete next three situations.]

4. 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. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.) Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

5. 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 look up your 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 for our share of the cost.

6. 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 for our share of the cost.

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

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. [*Insert as applicable:* Chapter 7 *OR* 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

[Plans may edit this section to include a second address if they use different addresses for processing medical and drug claims.]

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 will help us process the information faster.

Either download a copy of the form from our website (*[insert URL]*) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)]

[Plans with different addresses for Part C and Part D claims may modify this paragraph as needed and include the additional address] Mail your request for payment together with any bills or receipts to us at this address:

[insert address]

[*If the plan allows members to submit oral payment requests, insert the following language:* You may also call our plan to request payment. For details, go to Chapter 2, Section 1 and look for the section called, *[plans may edit section title as necessary]* 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.]

[*Insert if applicable:* **You must submit your claim to us within *[insert timeframe]*** of the date you received the service, item, or drug.]

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, 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

Section 3.1 We check to see whether we should cover the service [*if applicable:* 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 make a coverage decision.

- If we decide that the medical care [*if applicable:* or drug] is covered and you followed all the rules for getting the care [*if applicable:* or drug], we will pay for our share of the cost. If you have already paid for the service [*if applicable:* or drug], we will mail your reimbursement of our share of the cost to you. If you have not paid for the service [*if applicable:* 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 covered. [*If applicable:* Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.])
- If we decide that the medical care [*if applicable:* 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.

Section 3.2 If we tell you that we will not pay for all or part of the medical care [*if applicable:* or drug], you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, 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 [*insert as applicable:* Chapter 7 *OR* Chapter 9] of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal 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 [*insert as applicable:* Chapter 7 *OR* 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 [*insert as applicable:* Chapter 7 *OR* 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 5.3 in [*insert as applicable:* Chapter 7 *OR* Chapter 9].
- [*If applicable:* If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.]

SECTION 4 Other situations in which you should save your receipts and send copies to us

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

[MA-only: delete this section.]

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 the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of 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 our price

[Plans with neither a coverage gap nor a deductible should delete this section.]

Sometimes when you are in the [*insert if applicable:* Deductible Stage *OR* Coverage Gap Stage *OR* Deductible Stage and Coverage Gap Stage] you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our 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:** If you are in the [*insert if applicable:* Deductible Stage *OR* Coverage Gap Stage *OR* Deductible Stage and Coverage Gap Stage], we [*insert as applicable:* will *OR* may] not pay for any share of these drug costs. But sending a copy of 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, we will not pay for any share of these drug costs. But sending a copy of 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

Chapter 8. Your rights and responsibilities

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Section 1.1 *[Plans may edit the section heading and content to reflect the types of alternate format materials available to plan members. Plans may not edit references to language except as noted below.]* We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.).....166

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[Note: Plans may add to or revise this chapter as needed to reflect NCQA-required language.]

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

Section 1.1 *[Plans may edit the section heading and content to reflect the types of alternate format materials available to plan members. Plans may not edit references to language except as noted below.]* We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)

[Plans must insert a translation of Section 1.1 in all languages that meet the language threshold.]

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

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. *[If applicable, plans may insert information about the availability of written materials in languages other than English.]* We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact *[Name of Civil Rights Coordinator]*.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with *[insert plan contact information]*. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact *[plan customer service]* for additional information.

Section 1.2 We must ensure that you get timely access to your covered services [*insert if applicable:* and drugs]

You may seek care from any provider in the United States, if the provider agrees to accept our plan's terms and conditions of payment prior to providing services to you and is eligible to provide services under Original Medicare, as described in Chapter 3, Section 1.2. You should always (except possibly in emergencies) show the provider your PFFS plan membership card. *[Non-network PPFS plans may edit this sentence to remove network references]* 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*.

[*Non-network PFFS plans insert:* A provider can decide whether to accept our plan's terms and conditions of payment each time you see the provider.]

[*Partial and full network PFFS plans insert*: Our plan has agreements with some providers to deliver covered services to members in our plan. These providers are our network providers. Chapter 3, Section 1.2 describes the rules for getting covered services using our network providers.]

[*Insert if applicable:* 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 [*insert if applicable:* or Part D drugs] within a reasonable amount of time, [*insert as appropriate:* Chapter 7 *OR* Chapter 9], [*insert as appropriate:* Section 9 *OR* Section 10] of this booklet tells what you can do. (If we have denied coverage for your medical care [*insert if applicable:* or drugs] and you don't agree with our decision, [*insert as appropriate:* Chapter 7 *OR* Chapter 9], Section 4 tells what you can do.)

Section 1.3 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 enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information [*MA-PD plans insert:* 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 work with your health care provider to 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 printed on the back cover of this booklet).

[Note: Plans may insert custom privacy practices.]

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

[Non-network PFFS plans may edit the title of this section to remove network reference.]

[Plans may edit the section to reflect the types of alternate format materials available to plan members and/or language primarily spoken in the plan service area.]

As a member of *[insert 2021 plan name]*, 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 printed on the back 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 number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- *[Non-network PFFS plans may omit or revise this bullet as necessary]* **Information about our network providers** [*insert if applicable:* **including our network pharmacies**]**.**

- For example, you have the right to get information from us about the qualifications of the providers [*insert if applicable:* and pharmacies] in our network and how we pay the providers in our network.
- *[Plans that combine the provider and pharmacy directory may combine this bullet and the one below and edit the information as needed]* For a list of the providers in the plan's network, see the *[insert name of provider directory]*.
- [*Insert if applicable:* For a list of the pharmacies in the plan's network, see the *[insert name of pharmacy directory]*.]
- For more detailed information about our providers [*insert if applicable:* or pharmacies], you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at *[insert URL]*.

- **Information about your coverage and the rules you must follow when 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.
  - [*Insert if applicable:* 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 (Formulary)*, 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 printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service [*insert if applicable:* 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. *[Non-network, MA-only plans may delete the following sentence]* You have the right to this explanation even if you received the medical service [*insert if applicable:* or drug] from an out-of-network provider [*insert if applicable:* or pharmacy]. [*Non-network MA-PD plans should replace the previous sentence with:* You have the right to this explanation even if you received the drug from an out-of-network pharmacy.]
  - If you are not happy or if you disagree with a decision we make about what medical care [*insert if applicable:* or Part D drug] is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see [*insert as applicable:* Chapter 7 *OR* Chapter 9] of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. ([*Insert as applicable:* Chapter 7 *OR* 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 [*insert if applicable:* or a Part D prescription drug], see [*insert as applicable:* Chapter 5 *OR* Chapter 7] of this booklet.

Section 1.5 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. [*Insert if applicable:* 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. [*MA-PD plans insert:* You also have the right to stop taking your medication.] Of course, if you refuse treatment [*MA-PD plans insert:* 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 coverage for 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. [*Insert as applicable:* Chapter 7 *OR* 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

[Note: Plans that would like to provide members with state-specific information about advanced directives, including contact information for the appropriate state agency, may do so.]

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 printed on the back 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 did not follow the instructions in it, you may file a complaint with *[insert appropriate state-specific agency (such as the State Department of Health)]*. *[Plans also have the option to include a separate exhibit to list the state-specific agency in all states, or in all states in which the plan is filed, and then should revise the previous sentence to make reference to that exhibit.]*

Section 1.6 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. 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 printed on the back cover of this booklet).

Section 1.7 What can you do if you believe 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 believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe 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 printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.8 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 printed on the back cover of this booklet).

- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact the **Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - 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

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 printed on the back 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.
  - [*Insert if applicable:* Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.]
- **If you have any other health insurance coverage** [*insert if applicable:* **or prescription drug coverage**] **in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
  - 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 [*insert if applicable:* and drug] benefits you get from our plan with any other health [*insert if applicable:* and drug] benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **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 [*insert if applicable:* 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, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- 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.]
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For most of your medical services [*insert if applicable:* or drugs] covered by the plan, you must pay your share of the cost when you get the service [*insert if applicable:* 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 tells what you must pay for your medical services. [*Insert if applicable:* Chapter 6 tells what you must pay for your Part D prescription drugs.]
  - If you get any medical services [*insert if applicable:* or drugs] that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service [*insert if applicable:* or drug], you can make an appeal. Please see [*insert as applicable:* Chapter 7 *OR* Chapter 9] of this booklet for information about how to make an appeal.

[Plans that do not disenroll members for non-payment may modify this section as needed.]

  - [*Plans offering Part D, insert:* If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.]
  - [*Part D plans, insert:* If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.]

- **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 printed on the back cover of this booklet).
  - **If you move *outside* of our plan service area, you** *[if a continuation area is 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, you will have a Special Enrollment Period when you can join any Medicare plan available in your new 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.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **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 printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 9

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

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

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

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” or “at-risk 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 us

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.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us 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.

The services of SHIP counselors are free. *[Plans providing SHIP contact information in an exhibit may revise the following sentence to direct members to it]* 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?

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, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

No. My problem is not about benefits or coverage.

Skip ahead to [*insert as applicable:* **Section 9** *OR* **Section 10**] at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

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

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services [*insert if applicable:* 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 we make about your benefits and coverage or about the amount we will pay for your medical services [*insert if applicable:* or drugs]. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will

cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service [*insert if applicable:* or drug] is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage 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 Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

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 printed on the back cover of this booklet).
- You **can get free help** from your State Health Insurance Assistance Program (see Section 2 of this chapter).
- [*MA-only plans, insert:* **Your doctor can make a request for you.** For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically

forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.]

- [*MA-PD plans, insert:* **Your doctor can make a request for you.**
  - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.]
- **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 (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf [*plans may also insert:* or on our website at *[insert website or link to form]*].) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are [*insert as applicable:* three *OR* 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:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- *[MA-only plans: omit this bullet]* **Section 6** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"

- [*Insert as applicable:* **Section 6** *OR* **Section 7**] of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- [*Insert as applicable:* **Section 7** *OR* **Section 8**] of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). 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.

Section 5.1 This section tells what to do if you have problems getting coverage for 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 benefits are 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. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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 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 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 coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
    - NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
        - [*Insert as applicable:* Chapter 7 *OR* Chapter 9], [*insert as applicable:* Section 6 *OR* Section 7]: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
        - [*Insert as applicable:* Chapter 7 *OR* Chapter 9], [*insert as applicable:* Section 7 *OR* Section 8]: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
    - 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.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
To find out whether we will cover the medical care you want.	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
If we already told you that rwe will not cover or pay for a medical service in the way that you want it to be covered or paid for.	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
If you want to ask us to pay you back for medical care you have already received and paid for.	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (How to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms
When a coverage decision involves your medical care, it 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 coverage decision."

Legal Terms
A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1.2 and look for the section called, *How to contact us 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 coverage decision means we will give you an answer within 14 calendar days** after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug, we will give you an answer within 72 hours** after we receive your request.

- **However,** for a request **for a medical item or service we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records [*full and partial network plans insert:* from out-of-network providers]) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- 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 [*insert as applicable:* Section 9 *OR* Section 10] of this chapter.)

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

- **A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
  - **However,** for a request **for a medical item or service we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records [*full and partial network plans insert:* from out-of-network providers]), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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 [*insert as applicable:* Section 9 *OR* Section 10] of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage 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 coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage 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 coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see [*insert as applicable:* Section 9 *OR* Section 10] of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast" coverage decision

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours.**
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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. (For more information about the process for making complaints, including fast complaints, see [*insert as applicable:* Section 9 *OR* Section 10] of this chapter.
  - 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), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request.** If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
  - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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. (For more information about the process for making complaints, including fast complaints, see [*insert as applicable:* Section 9 *OR* Section 10] of this chapter.)
  - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an 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 we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say 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 an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

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

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start an appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1.2 and look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a 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 1.2 (*How to contact us when you are making an appeal about your medical care*).]
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf [*plans may also insert:* or on our website at *[insert website or link to form]*].) While we can accept an appeal request without the form, we cannot begin or complete

our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 *[plan may edit section title as needed]* (*How to contact us 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, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - 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" (you can make a request by calling us)

Legal Terms
A "fast appeal" is also called an **"expedited reconsideration."**

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or 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 coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this Section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When we are 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 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 calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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 automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you 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 authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 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 calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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. (For more information

about the process for making complaints, including fast complaints, see [*insert as applicable:* Section 9 *OR* Section 10] of this chapter.)

- If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review 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 authorize or provide the coverage we have agreed to provide within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

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

- To make sure we were following all the rules when we said no to your appeal, **we are 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.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say 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 our decision for 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 independent organization that is hired by Medicare**. This organization is not connected with us 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.]
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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 a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date we receive the decision from the review organization for expedited requests.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review

organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests**.

- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of 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.")
  - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to 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. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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. The details on how to do this are in the written notice you get after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. [*Insert as applicable:* Section 8 *OR* Section 9] in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading [*insert as applicable:* Chapter 5 *OR* Chapter 7] of this booklet: *Asking us to pay our share of a bill you have received for covered medical services [insert if applicable: or drugs]*. [*Insert as applicable:* Chapter 5 *OR* 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 us

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 within 60 calendar days after we receive your request. 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 in detail. (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 do not agree with our decision to turn 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 Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (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.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

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

[MA-only plans: omit Section 6, re-number remaining sections in Chapter 9, and change cross-references to section numbers.]

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.

Section 6.1 This section tells you 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 prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **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 (Formulary)*, 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*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms
An initial coverage decision about your Part D drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions: omit this bullet]* Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)

- *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
If you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover.	You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter.
If you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need.	You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.
If you want to ask us to pay you back for a drug you have already received and paid for.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.
If we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." 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, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are

[*insert as applicable:* two *OR* three] examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *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 tier] OR drugs in [insert exceptions tier] for brand name drugs or [insert exceptions tier] for generic drugs*]. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

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.
- *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions: omit this bullet]* If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions: omit this section]* **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of *[insert number of tiers]* cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms
Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.

  - *[Plans that have a formulary structure where all of the biological products are on one tier or that do not limit their tiering exceptions in this way: omit this bullet]* If the drug you're taking is a biological product you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains biological product alternatives for treating your condition.

  - *[Plans that do not limit their tiering exceptions in this way; omit this bullet]* If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.

  - *[Plans that do not limit their tiering exceptions in this way; omit this bullet]* If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.

- [*If the plan designated one of its tiers as a "specialty tier" and is exempting that tier from the exceptions process, include the following language:* You cannot ask us to change the cost-sharing tier for any drug in *[insert tier number and name of tier designated as the high-cost/unique drug tier]*.]

- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber 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. *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions: omit this statement]* If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If 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 and effective 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.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *[plans may edit section title as necessary] How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *[plans may edit*

section title as necessary] 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.

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. 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.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered 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.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form [*insert if applicable:* or on our plan's form], which [*insert if applicable:* is *OR* are] available on our website.
- *[Plans that allow members to submit coverage determination requests electronically through, for example, a secure member portal may include a brief description of that process.]*

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

Legal Terms
A "fast coverage decision" is called an **"expedited coverage determination."**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage 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 coverage decision," we will automatically agree to give you a fast coverage decision.**

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage 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 coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast complaint," which means you would get our answer to your complaint within 24 hours of receiving the complaint. (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: We consider your request 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 request. If you are requesting an exception, we will give you our answer 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 Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or 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. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 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 Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or 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. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

We must give you our answer **within 14 calendar days** after we receive your request.

- 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 Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

If our answer is yes to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive 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. We will also tell you how you can appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

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
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1: You contact us 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 us.**
  - For details on how to reach us by phone, fax, or mail, or on our website, 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 contact us when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written 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 contact our plan when you are making an appeal about your Part D prescription drugs*).]
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** *[plans may edit section title as necessary]* (*How to contact us when you are making an appeal about your Part D prescription drugs*).
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- *[Plans that allow members to submit appeal requests electronically through, for example, a secure member portal may include a brief description of that process.]*
- **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. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an 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 redetermination."**

- If you are appealing a decision we 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."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- 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 Review Organization. Later in this section, we talk about this review 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 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 you can 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 for a drug you have not received yet. 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 you believe your health requires it, you should ask for "fast" appeal.
  - 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 Review Organization. Later in this section, we talk about this review 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 –**
  - If we approve a request for coverage, 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 we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal 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 and how you can appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer within **14 calendar days** after we receive your request.
  - If we do not give you a decision within 14 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 Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive 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. We will also tell you how you can 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 we say 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).

Section 6.6 Step-by-step: How to make a Level 2 Appeal

If we say 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 we 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 (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say 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 we have 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.]
- You have a right to give the Independent Review Organization additional information to support your appeal.

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

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- 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 "fast" appeal at Level 2

- 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** after it receives your appeal request.
- **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 "standard appeal" at Level 2

- 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** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal **within 14 calendar days** after it receives your request.

- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, 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.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** 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 the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, 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.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

[MA-only plans: Renumber sections 7 through 10 and update cross references as needed.]

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 our 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 covered 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**."
- 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.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered 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 (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). 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.

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 your right to know who will pay for it.
    - Where to report any concerns you have about quality of your hospital care.

- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms
The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. ([*Insert as applicable:* Section 6.2 *OR* Section 7.2] below tells you how you can request an immediate review.)

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked t 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 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 two 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 (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

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 inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. 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 printed on the back 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.

Step 1: Contact the Quality Improvement Organization for 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 About Your Rights*) 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 [*insert as applicable:* Section 6.4 *OR* Section 7.4].

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 we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we 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 (phone numbers are printed on the back cover of this booklet) 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 see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

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, **we must keep providing your covered inpatient 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. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and 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.

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. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

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 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this

review only if you stay in the hospital after the date that your coverage for the care ended.

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 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We 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. **We must continue providing coverage for your inpatient 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 on your Level 1 Appeal and will not change it. This is called "upholding the decision."

- 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 an Administrative Law Judge or attorney adjudicator.

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 an Administrative Law Judge or attorney adjudicator.
- [*Insert as applicable:* Section 8 *OR* Section 9] in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in [*insert as applicable:* Section 6.2 *OR* 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, whichever comes first.) 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 us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

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

<u>Step 1:</u> Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1.2 and look for the section called, *How to contact us 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.

<u>Step 2:</u> We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take 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: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say 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 inpatient hospital 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 we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient 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 we say *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 following all the rules when we said no to your fast appeal, **we are 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: Level 2 Alternate Appeal Process

During the Level 2 Appeal, an Independent Review Organization reviews the decision we made when we said no to your "fast 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: We will automatically forward your case to the Independent Review Organization.

- 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. [*Insert as applicable:* Section 9 *OR* 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 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 we 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 inpatient 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 us that your planned hospital discharge date was medically appropriate.
    - 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 a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

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.
- [*Insert as applicable:* Section 8 *OR* Section 9] in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

Section 8.1 This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

- Home health care services you are getting.
- Skilled nursing care you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see [*insert as applicable:* Chapter 10 *OR* Chapter 12], *Definitions of important words*.)
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see [*insert as applicable:* Chapter 10 *OR* 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 we decide 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, *we will stop paying our share of the cost for your care.*

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

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, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - 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 you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. ([*Insert as applicable:* Section 7.3 *OR* Section 8.3] below tells how you can request a fast-track appeal.)
The written notice is called the "**Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) 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 www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html

2. **You will be asked to sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf will be asked to 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.

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. 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. [*Insert as applicable:* Section 9 *OR* 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 printed on the back 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.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for 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 for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care*.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see [*insert as applicable:* Section 7.5 *OR* Section 8.5].

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.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice 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 **we 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.** We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *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 to 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.

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. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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 of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

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

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We 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 we made to your Level 1 Appeal and will not change it.
- 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 an Administrative Law Judge or attorney adjudicator.

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 to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.

- [*Insert as applicable:* Section 8 *OR* Section 9] in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in [*insert as applicable:* Section 7.3 *OR* Section 8.3], 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 us, 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 appeal"**.

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1.2 and look for the section called, *How to contact us 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: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were 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.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say 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 we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are 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: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast 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: We will automatically forward your case to the Independent Review Organization.

- 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. [*Insert as applicable:* Section 9 *OR* 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 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 we 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.
    - 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 a Level 3 Appeal.

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 an Administrative Law Judge or attorney adjudicator.

- [*Insert as applicable:* Section 8 *OR* 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

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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 item 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.

Level 3 Appeal	**A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.

  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.

  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, 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 Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.

  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.

  - If we decide to appeal the decision, we will let you know in writing.

- **If the answer is no or if the Council denies the review request, 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. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 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.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

[MA-only plans: delete this section.]

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 value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. 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.

Level 3 Appeal	**A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **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 Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **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. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 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.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

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.

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"

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?

Complaint	Example
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 Member Services has treated you? • Do you feel you are being encouraged to leave the plan?
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, [*Part D plans insert:* pharmacists,] or other health professionals? Or by our Member Services or other staff at the plan? o Examples include waiting too long on the phone, in the waiting room, [*Part D plans insert:* when getting a prescription,] or in the exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (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-[*insert as applicable:* 8 *OR* 9] of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are 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 we are told that we must cover or reimburse you for certain medical services [*Part D plans insert:* or drugs], there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization.

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."**

Section 10.3 Step-by-step: Making a complaint

<u>Step 1:</u> 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, and days 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 put your complaint in writing, we will respond to your complaint in writing.
- *[Insert description of the procedures (including time frames) and instructions about what members need to do if they want to use the process for making a complaint. 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 calendar 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 coverage decision" or a "fast 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 an **"expedited 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.
- **Most complaints are answered within 30 calendar 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 calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **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. We must respond whether we agree with the complaint or not.

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 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 us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work 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 us and also to the Quality Improvement Organization.

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about *[insert 2021 plan name]* directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10

Ending your membership in the plan

Chapter 10. Ending your membership in the plan

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SECTION 1 Introduction

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

Ending your membership in *[insert 2021 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 voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily 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 you do not choose to leave, but 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 [*insert if applicable:* and prescription drugs] 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.

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 Open Enrollment Period"). This is the time when you should review your health [*insert if appropriate:* and drug] coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** 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 health 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.
    - *[MA-only plans, omit]* **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

[MA-only plans, omit] **Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

- **What do you need to do to switch plans?**

[*MA-PD plans insert bullets below:*

- If you want to switch to Original Medicare and join a Medicare prescription drug plan: Simply join the new plan. You will be disenrolled from our plan and enrolled in Original Medicare when your new drug plan's coverage begins.
- If you are planning on switching to Original Medicare without a drug plan: Contact Member Services for information on how to request disenrollment (phone numbers are printed on the back cover of this booklet). You may also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to request disenrollment from our plan. TTY users should call 1-877-486-2048.]

[*MA-only plans insert bullets and text below:*

- If you want to switch to Original Medicare: You must ask to disenroll from our plan. For more information on how to request disenrollment contact Member Services (phone numbers are printed on the back cover of this booklet). You may also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to request disenrollment from our plan. TTY users should call 1-877-486-2048.
- If you are currently enrolled in a separate Medicare prescription drug plan:
    - Leaving our plan will not affect your enrollment in your drug plan.
    - If you want to join a new drug plan, you must request enrollment in the new drug plan of your choice. Switching your Medicare prescription drug plan will *not* automatically disenroll you from our plan.
- If you do not have Medicare prescription drug coverage with another plan, you can join another Medicare health plan that does not offer drug coverage or you can switch to Original Medicare.]

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

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

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:
    - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
    - Disenroll from our plan and obtain coverage through Original Medicare. [*MA-PD plans insert the following:* If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.] [*MA-only plans insert the following:* If you are enrolled in a separate Medicare prescription drug plan, you may not cancel that coverage when you switch to Original Medicare.]
- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. [*MA-PD plans insert the following:* If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.]

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

In certain situations, members of *[insert 2021 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?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
    - Usually, when you have moved.
    - *[Revise bullet to use state-specific name, if applicable]* If you have Medicaid.
    - If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
    - If we violate our contract with you.

- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- [*Plans in states with PACE, insert:* If you enroll in the Program of All-inclusive Care for the Elderly (PACE).]
- [**Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.]

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, 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. 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 health 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.
    - *[MA-only plans, omit]* **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  [MA-only plans, omit] **Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.
- **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.

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 printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2021*** 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 the Medicare website (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?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare [*MA-PD plans insert: without* a Medicare prescription drug plan], you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet);
- --*or*--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.

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 health plan.	• Enroll in the new Medicare health plan between October 15 and December 7. You will automatically be disenrolled from *[insert 2021 plan name]* when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan between October 15 and December 7. You will automatically be disenrolled from *[insert 2021 plan name]* when your new plan's coverage begins. • [*MA-only plans replace bullet above with the following three bullets:* **Send us a written request to disenroll.** Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). **Then contact the Medicare prescription drug plan that you want to enroll in and ask to be enrolled.** • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from *[insert 2021 plan name]* when your coverage in Original Medicare begins. If you join a Medicare prescription drug plan, that coverage should begin at this time as well.]
• Original Medicare *without* a separate Medicare prescription drug plan. o **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage for 63 days or more in a row, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 1, Section 5 for more information about the late enrollment penalty.	• **Contact Member Services and ask to be disenrolled from the plan (phone numbers are printed on the back cover of this booklet).** • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from *[insert 2021 plan name]* when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services [*insert if applicable:* **and drugs**] through our plan

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

If you leave *[insert 2021 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 [*insert if applicable:* and prescription drugs] through our plan.

- **[*Insert if applicable:* 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, your hospital stay 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 2021 plan name]* must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

[Insert 2021 plan name] **must end your membership in the plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months. *[Plans with visitor/traveler benefits should revise this bullet to indicate when members must be disenrolled from the plan.]*
    - 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. (Phone numbers for Member Services are printed on the back cover of this booklet.)
    - [*Full and partial network plans that offer a visitor/traveler benefit insert the following sentence:* Go to Chapter 4, Section 2.3 for information on getting care when you are away from the service area through our plan's visitor/traveler benefit.]
    - [*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 are still eligible as long as you have not moved since before January 1999. 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 become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- 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. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- *[Omit 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. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - 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. Plans with different disenrollment policies for dual eligible members and/or members with LIS who do not pay plan premiums must edit these bullets as necessary to reflect their policies. Plans with different disenrollment policies must be very clear as to which population is excluded from the policy to disenroll for failure to pay plan premiums.]* If you do not pay the plan premiums for *[insert length of grace period, which cannot be less than two calendar months]*.
    - We must notify you in writing that you have *[insert length of grace period, which cannot be less than two calendar months]* to pay the plan premium before we end your membership.
- *[MA-only plans, omit]* If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

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 printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

[Insert 2021 plan name] is not allowed to 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.

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 file a grievance or make a complaint about our decision to end your membership. You can also look in [*insert as applicable:* Chapter 7 *OR* Chapter 9], [*insert as applicable:* Section 9 *OR* Section 10] for information about how to make a complaint.

CHAPTER 11

Legal notices

Chapter 11. Legal notices

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SECTION 3 Notice about Medicare Secondary Payer subrogation rights.....248

[Note: You may include other legal notices, such as a notice of member non-liability, a notice about third-party liability or a nondiscrimination notice under Section 1557 of the Affordable Care Act. 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 non-discrimination

[Plans may add language describing additional categories covered under state human rights laws.] Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. 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, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 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 printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, *[insert 2021 plan name]*, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

[Note: You may include other legal notices, such as a notice of member non-liability, a notice about third-party liability or a nondiscrimination notice under Section 1557 of the Affordable Care Act. These notices may only be added if they conform to Medicare laws and regulations.]

CHAPTER 12

Definitions of important words

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 allowable revisions to terminology (e.g., changing "Member Services" to "Customer Service") affect glossary terms, plans should re-label the term and alphabetize it within the glossary.]

[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.]

[MA-only plans should delete the following definitions: Brand Name Drug, Catastrophic Coverage Stage, Cost-Sharing Tier, Covered Drugs, Dispensing Fee, Exception, Generic Drug, Initial Coverage Stage, List of Covered Drugs, Network Pharmacy, Out-of-Network Pharmacy, Part D Drugs, Quantity Limits, Step Therapy.]

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of 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 our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. [*Insert as applicable:* Chapter 7 *OR* Chapter 9] explains appeals, including the process involved in making an appeal.

Balance Billing – *[Plans that allow balance billing may edit the percentage to reflect their actual balance billing rate.]* When a provider (such as a doctor or hospital) bills a patient up to 15% more than the plan's payment amount for services. The "balance billing" amount is collected in addition to the patient's regular plan cost-sharing amount. [*Plans that prohibit balance billing insert:* As a member of *[insert 2021 plan name]*, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.] See Chapter 4, Section 1.6 for more information about balance billing.

Benefit Period – *[Modify definition as needed if plan uses benefit periods for SNF stays but not for inpatient hospital stays.]* The way that [*insert if applicable:* both our plan and] Original

Medicare measures your use of hospital and skilled nursing facility (SNF) services. *[Plans that offer a more generous benefit period, revise the following sentences to reflect the plan's benefit period.]* A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. [*Insert if applicable:* You must pay the inpatient hospital deductible for each benefit period.] There is no limit to the number of benefit periods.

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 2021 out-of-pocket threshold]* in covered drugs during the covered year.

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

Coinsurance – An amount you may be required to pay as your share of the cost for services [*insert if applicable:* or prescription drugs] [*insert if applicable:* after you pay any deductibles]. Coinsurance is usually a percentage (for example, 20%).

Complaint – The formal name for "making a complaint" is "filing a grievance." 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. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services [*insert if applicable:* or drugs] are received. [*Insert if plan has a premium:* (This is in addition to the plan's monthly premium.)] Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services [*insert if applicable:* or drugs] are covered; (2) any fixed "copayment" amount that a plan requires when a specific

service [*insert if applicable:* or drug] is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service [*insert if applicable:* or drug], that a plan requires when a specific service [*insert if applicable:* or drug] is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

[Delete if plan does not use tiers] **Cost-Sharing Tier** – Every drug on the list of covered drugs is in one of *[insert number of tiers]* cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision 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. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

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

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

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

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care [*insert if applicable:* or prescriptions] before our plan begins to pay.

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).

[MA-only plans, omit] **Dispensing Fee –** A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, 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 decision 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 a lower 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).

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.

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, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about us [*insert if applicable:* 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.

Hospice - A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

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

Initial Coverage Stage – This is the stage before your [*insert as applicable:* total drug costs including amounts you have paid and what your plan has paid on your behalf *OR* out-of-pocket costs] for the year have reached [*insert as applicable: [insert 2021 initial coverage limit] OR [insert 2021 out-of-pocket threshold]*.]

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered 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 (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered [*insert if applicable:* Part A and Part B] services. *[MA-only plans and plans without a premium revise the following sentence as needed]* Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. [*Plans with service category MOOPs insert:* In addition to

the maximum out-of-pocket amount for covered [*insert if applicable:* Part A and Part B] Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services.] See Chapter 4, Section 1*[insert subsection number]* for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare [*insert only if there is a cost plan in your service area:*, a Medicare Cost Plan,] [*insert only if there is a PACE plan in your state:* a Programs of All-inclusive Care for the Elderly (PACE) plan,] or a Medicare Advantage Plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is from January 1 until March 31, and is also available for a 3-month period after an individual is first eligible for Medicare.

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 and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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** – A Medicare Cost Plan is 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 Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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 have an agreement with our plan to accept our payment as payment in full, and in some cases to

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

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

Organization Determination - The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. [*Insert as applicable:* Chapter 7 *OR* Chapter 9] explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, 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. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network 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.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not signed a contract or 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-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services [*insert if applicable:* or drugs] received is also referred to as the member's "out-of-pocket" cost requirement.

[*Insert PACE plan definition only if there is a PACE plan in your state:* **PACE plan** – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.]

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.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive "Extra Help," you will not pay a late enrollment penalty.

[*Include this definition only if Part D plan has pharmacies that offer preferred cost-sharing in addition to those offering standard cost-sharing:*

Preferred Cost-sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.]

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage 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. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

[Plans that do not use PCPs, omit] **Primary Care** [*insert as appropriate:* Physician *OR* Provider] **(PCP)** – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care [*insert as appropriate:* Physicians *OR* Providers].

Prior Authorization – Approval in advance to get services [*if applicable*: and/or certain drugs that may or may not be on our formulary. Some drugs 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.] In a PFFS plan, you do not need prior authorization to obtain services. However, you may want to check with your plan before obtaining services to confirm that the service is covered by your plan and what your cost-sharing responsibility is.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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 – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

[*Include this definition only if Part D plan has pharmacies that offer preferred cost-sharing in addition to those offering standard cost- sharing:*

Standard Cost-sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.]

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 Social Security 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.

[*Full-network plans insert:* **Urgently Needed Services** – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.]

[This is the back cover for the EOC. Plans may add a logo and/or photographs, as long as these elements do not make it difficult for members to find and read the plan contact information.]

[Insert 2021 plan name] Member Services

Method	Member Services – Contact Information
CALL	*[Insert phone number(s)]* Calls to this number are free. *[Insert days and hours of operation, including information on the use of alternative technologies.]* Member Services also has free language interpreter services available for non-English speakers.
TTY	*[Insert number]* [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. *[Insert days and hours of operation.]*
FAX	*[Optional: insert fax number]*
WRITE	*[Insert address]* *[Note: plans may add email addresses here.]*
WEBSITE	*[Insert URL]*

[Insert state-specific SHIP name] [*If the SHIP's name does not include the name of the state, add:* (*[insert state name]* SHIP)]

[Insert state-specific SHIP name] is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

[Plans with multi-state EOCs revise heading and sentence above to use "State Health Insurance Assistance Program," omit table, and reference exhibit or EOC section with SHIP information.]

Method	Contact Information
CALL	*[Insert phone number(s)]*
TTY	*[Insert number, if available. Or delete this row.]* [*Insert if the SHIP uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]
WRITE	*[Insert address]*
WEBSITE	*[Insert URL]*

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