**Instructions to Health** **Plans**

* [Distribution Note: Enrollment – Plans must provide a Directory to each member upon enrollment. Refer to the Medicare Marketing Guidelines for detailed instructions.]
* [If the state does not use the word “Medicaid,” plans should replace it with the name the state uses.]
* [If plans do not use the term “Member Services,” plans should replace it with the term the plan uses.]
* [Plans should note that the EOC is referred to as the “Member Handbook.”   
  If plans do not use the term “Member Handbook,” plans should replace it with   
  the term the plan uses.]
* [Plans should indicate that the Directory includes providers of both Medicare and Medicaid services.]
* [Plans may place a QR code on materials to provide an option for members   
  to go online.]

## <Plan name> | Directorio de proveedores y farmacias para <year>

* <Plan’s legal or marketing name> es un plan de salud que tiene contrato con Medicare y Medicaid de Illinois para proporcionar los beneficios de los dos programas a los miembros.
* Los beneficios, la Lista de medicamentos cubiertos [, y] las redes de farmacias y proveedores [, y/o copagos,] pueden cambiar en cualquier momento durante el año y el 1º de enero de cada año.
* Usted puede pedir esta información en otros formatos, como Braille o letra grande. Llame al <toll-free number>. La llamada es gratuita.
* You can get this document in English or speak with someone about this information in other languages for free. Call <toll-free number>. The call is free.  
  Usted puede obtener este documento en inglés o hablar con alguna persona sobre esta información en otros idiomas de manera gratuita. Llame al <toll-free number>. La llamada es gratuita. [The preceding sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]
* Este Directorio contiene los profesionales del cuidado de salud (como médicos, enfermeras de práctica avanzada y sicolólogos) o las instituciones (como hospitales o clínicas) y los proveedores de respaldo (como las Guarderías para adultos mayores y proveedores de salud en el hogar) que usted puede visitar como miembro de <plan name>. También contiene las farmacias que usted puede usar para recibir sus medicamentos de receta.
* En este Directorio nos referiremos a este grupo como "proveedores de la red". Estos proveedores firmaron un contrato con nosotros para proporcionarle servicios a usted. Ésta es una lista de proveedores de la red de <plan name>para [describe the plan’s service area, and include a list of counties and cities/towns].

La lista está al corriente hasta el <date of publication>, pero usted debe saber que:

* Podríamos haber agregado o retirado algunos proveedores de la red de<plan name> después de la impresión de este Directorio.
* Posiblemente algunos proveedores de <plan name> de nuestra red no acepten miembros nuevos. Si usted tiene algún problema para encontrar un proveedor que acepte miembros nuevos, llame a Servicios a los miembros al <toll-free number> y le ayudaremos.
* Para obtener la información más actual sobre la red de proveedores de <plan name> en su área, vaya a <web address> o llame a Servicios a los miembros al <toll-free number>, <days and hours of operation>. La llamada es gratuita. [TTY/TDD:   
  <phone number>.]

Los médicos y profesionales de cuidado de salud de la red de <plan name> están anotados en las páginas <page numbers>.

Las farmacias de nuestra red se encuentran en las páginas <page numbers>.

# Proveedores

## Cómo comenzar con <plan name>

[States should feel free to modify this section as necessary. For example, States that use integrated Primary Care Teams should explain the composition of the teams and how they work. Plans should also include information about the integrated individual care plans developed for each member as applicable to the model of care.]

Esta sección explica términos claves que usted encontrará en nuestro Directorio de proveedores y farmacias.

* **Los proveedores** son médicos, enfermeras, farmacéuticos, terapeutas y otras personas que proporcionan cuidado y servicios. **Los servicios** incluyen cuidado médico, servicios y respaldos a largo plazo, servicios, suministros, medicamentos de receta, equipos y otros servicios.

El término *proveedores* también incluye hospitales, clínicas y otros sitios que proporcionan servicios médicos, equipo médico y servicios y respaldos a largo plazo.

A los proveedores que son parte de la red de nuestro plan les llamamos **proveedores de la red**.

* **Los proveedores de la red** son los proveedores que tienen contratos para proporcionar servicios a los miembros de nuestro plan. [Plans may delete the next sentence if it is not applicable.] Los proveedores de nuestra red, de manera general, nos cobran directamente por el cuidado que le dan a usted. Cuando usted visite a un proveedor de la red, generalmente [Insert as applicable: no pagará nada **or** solamente pagará su parte del costo] por los servicios cubiertos.
* Un [insert the term the plan uses (e.g., **proveedor** **or** **medico**)] **personal (PCP)** es [plans should include examples as they see fit] quien le da el cuidado de salud de rutina. Su PCP llevará sus expedientes médicos y con el tiempo le conocerá a usted y sus necesidades de salud. [Health plans should include this sentence if applicable to plan arrangement: Su PCP también le dará una **preautorización** si usted tiene que consultar un especialista u otro proveedor.]
* **Los especialistas** son médicos que proporcionan servicios de cuidado de salud para una enfermedad o parte del cuerpo específicas. Existen muchos tipos de especialistas. Aquí hay unos cuantos ejemplos:

**Los** **oncólogos** cuidan de pacientes con cáncer.

**Los** **cardiólogos** cuidan de pacientes con enfermedades del corazón.

**Los** **ortopedistas** cuidan de pacientes con ciertas enfermedades óseas, de articulaciones o musculares.

* Posiblemente necesite una **preautorización** para ver a un especialista o a alguien que no sea su PCP. Una **preautorización** significa que [insert as applicable: su PCP de la red **or** nuestro plan] debe darle su aprobación antes de que usted pueda ver al otro proveedor. Si usted no obtiene la aprobación, <plan name> podría no cubrir el servicio.

No se necesitan preautorizaciones de [insert as applicable: su PCP de la red **or** nuestro plan] para:

* + - Cuidados de emergencia;
    - Cuidado necesario urgentemente;
    - Servicios de diálisis renal que usted recibe en una institución de diálisis certificada por Medicare, cuando usted está fuera del área de servicio del plan ***o***
    - Para ver a un especialista en salud femenina.
    - [Plans may insert additional exceptions as appropriate.]

Además, si usted es elegible para recibir servicios de proveedores de salud indios, usted puede ver estos proveedores sin preautorización. Debemos pagar al proveedor de salud indio por esos servicios, aunque estén fuera de la red de nuestro plan.

Encontrará más información sobre preautorizaciones en el Capítulo 3 del Manual del miembro.

* Usted también tiene acceso a un equipo de cuidados que usted ayuda a elegir.

Un **coordinador de cuidados**, que trabaja estrechamente con usted, dirigirá su equipo de cuidados y desarrollará un plan de cuidados de salud para ayudarle a administrar sus respaldos y servicios de salud del comportamiento y sus necesidades sociales y funcionales.

Su **equipo de cuidados** [plans should describe the care team as appropriate to the plan]. El coordinador de cuidados dirige a todos los integrantes del equipo de cuidados, quienes trabajan juntos para asegurarse que sus cuidados sean coordinados. Esto significa que se aseguran que sus proveedores estén al corriente de los cuidados que usted reciba, los medicamentos que usted toma y las pruebas y exámenes de laboratorio que le hacen y que los resultados sean compartidos con los proveedores apropiados. Su equipo de cuidados también evaluará sus necesidades para determinar si necesita ayuda en otras áreas, además de sus necesidades de salud, como sus necesidades físicas o sociales. Su equipo de cuidados estará en contacto con usted tan seguido como sea necesario, dependiendo del plan de cuidados que usted ayude a desarrollar.

El coordinador de cuidados y el equipo de cuidados desarrollarán, con su ayuda, un **plan de cuidados**. El plan de cuidados contendrá todas sus necesidades, fijará metas para atender esas necesidades y determinará las maneras de comprobar que esas necesidades sean satisfechas o si hay necesidad de cambiarlas. También incluirá un plan de servicios si usted recibe servicios basados en el hogar y la comunidad.

## Cómo elegir un [insert term the plan uses (e.g., Proveedor or Médico)] personal (PCP) [if appropriate, plans should include: o Equipo integral de cuidados personales]

Usted puede recibir servicios de cualquier proveedor de nuestra red que acepte miembros nuevos.

Primero, usted [tendrá que **or** deberá] elegir un [insert the term the plan uses (e.g., proveedor **or** médico)] personal. [If appropriate plans should include: Usted puede tener un especialista como su PCP]. [If this is applicable, plans should describe under what circumstances a specialists may act as a PCP and how to request one (e.g., llame a Servicios al miembro).]

Para elegir un PCP, vaya a la lista de [insert term the plan uses (e.g., proveedores, **or** médicos)] de la página<page number> y:

* Elija un [insert term the plan uses (e.g., proveedor **or** médico)] que usted consulte ahora ***o***
* Elija un [insert term the plan uses (e.g., proveedor **or** médico)] que le haya recomendado alguien en que usted confíe ***o***
* Elija un [insert term the plan uses (e.g., proveedor **or** médico)] que tenga un consultorio al que pueda llegar fácilmente.

[Plans may modify the bullet text listed above or add additional language as appropriate.]

* Si quiere ayuda para elegir un PCP, por favor llame a servicios al miembro al   
  <toll-free number>, <days and hours of operation>. La llamada es gratuita.   
  [TTY/TDD: <phone number>.] O, vaya a <web address>.
* Si tiene alguna pregunta sobre si pagaremos algún servicio o cuidado médico que usted quiera o necesite, llame a servicios a miembros para preguntar, *antes* de recibir los servicios o el cuidado.

## Cómo recibir servicios y respaldos a largo plazo

Usted podría obtener servicios y respaldos a largo plazo (LTSS), como [plans should provide examples with explanations of all services available to members] como miembro de <plan name>. Los Servicios y respaldos a largo plazo son ayuda para las personas que necesitan asistencia para realizar tareas cotidianas, como bañarse, vestirse, preparar comida y tomar medicamentos. La mayoría de esos servicios son proporcionados en su hogar o en su comunidad, pero podrían ser proporcionados en un hogar de cuidados para adultos mayores u hospital.

[Include information regarding accessing LTSS and talking with a Care Coordinator.]

## Cómo identificar los proveedores de la red de <plan name>

[Plans should delete this paragraph if they don’t require referrals for any services.] Posiblemente necesite una preautorización para consultar a una persona que no sea un [insert term the plan uses (e.g., proveedor **or** médico)] *personal.* Hay más información sobre preautorizaciones en la sección de "Cómo comenzar con <plan name>" de este Directorio de proveedores y farmacias, en la <page number>.

[HMO plan types must include the following language.] Usted deberá recibir todos sus servicios cubiertos de proveedores dentro de nuestra red. Si visita proveedores que no estén en la red de <plan name> (sin autorización previa de nosotros o sin nuestra aprobación), usted tendrá que pagar la factura.

Las excepciones a esta regla son cuando usted necesite cuidado urgente o de emergencia o diálisis y no puede ir a un proveedor del plan, como cuando usted y su familia están lejos de casa. [Plans may insert additional exceptions as appropriate.] Usted también puede ir fuera del plan para otros servicios fuera de emergencias, si <plan name> le da permiso antes.

* Usted puede cambiar de proveedores dentro de la red en cualquier momento. Si ha estado consultando un proveedor de la red, usted no tiene que seguir viendo a ese proveedor. [Plans should modify or add language with plan specific rules about PCP changes. Plans should include the following language if appropriate: Para algunos proveedores, posiblemente necesite una preautorización de su PCP.]
* <Plan name> trabaja con todos proveedores de nuestra red, para adaptarse a las necesidades de las personas con discapacidades. La lista de proveedores de la red de abajo incluye la información sobre las adaptaciones que proporcionan los proveedores. Si tiene que consultar a un proveedor y no está seguro de que ofrezca las adaptaciones que usted necesita, <plan name> puede ayudarle. Hable con su [insert as appropriate: equipo de cuidados, coordinador de cuidados, asistente certificado del paciente **or** similar] para que le ayuden.

## Cómo encontrar proveedores de <plan name> en su área

[Plan sponsors should describe how an enrollee can find a network provider nearest his or her home relative to the organizational format used in the Provider Directory.]

## Lista de proveedores de la red

[**Note:** Plans that provide additional or supplemental benefits beyond those captured in the provider types in this model document must create a category or categories of providers offering these additional or supplemental benefits and list the providers.]

[Show the total number of each type of provider (e.g., PCP, specialist, hospital, etc.).]

**Recommended organization:** [Plans are required to include all of the following fields but have discretion regarding the organizational layout used.]

1. **Type of Provider** [PCPs, Specialists, Hospitals, Skilled Nursing Facilities, Nursing Facilities, Mental Health Providers, Long-Term Services and Supports Providers, and Pharmacies where outpatient prescription drugs are offered by the plan. **Note:** All of these provider types are required to be listed in the same Provider Directory.]
2. **Condado** [List alphabetically.]
3. **Ciudad** [List alphabetically.]
4. **Barrio, Código postal** [Optional: For larger cities, providers may be further subdivided by zip code or neighborhood.]
5. **Proveedor** [List alphabetically.]

Usted puede recibir servicios de cualquiera de los proveedores de esta lista. [Plans should include the following language if referrals are required under the plan: Para algunos proveedores, posiblemente necesite una preautorización de su PCP.]

**[Sample formatting:]**

## Médicos personales

### <State> | <County>

##### <City/Town><Zip Code>

**<Physician Name>**

<Physician Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## Especialistas: <Specialty Type>

### <State> | <County>

##### <City/Town><Zip Code>

**<Physician Name>**

<Physician Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## Hospitales

### <State> | <County>

##### <City/Town><Zip Code>

**<Hospital Name>**

<Hospital Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## Instituciones de enfermería especializada (SNF)

### <State> | <County>

##### <City/Town><Zip Code>

**<SNF Name>**

<SNF Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## Instituciones de enfermería (NF)

### <State> | <County>

##### <City/Town><Zip Code>

**<NF Name>**

<NF Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## Proveedores de salud mental

### <State> | <County>

##### <City/Town><Zip Code>

**<Provider Name>**

<Provider Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## Servicios y respaldos a largo plazo: [Customize per state-specific LTSS (e.g., Servicios de guardería para adultos). Plans can add as many categories as necessary.]

### <State> | <County>

##### <City/Town><Zip Code>

**<Provider Name>**

<Provider Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## Servicios y respaldos a largo plazo: [Customize per state-specific LTSS (e.g., Vida con asistencia).]

### <State> | <County>

##### <City/Town><Zip Code>

**<Provider Name>**

<Provider Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## Servicios y respaldos a largo plazo: [Customize per state-specific LTSS (e.g., Servicios dirigidos por el consumidor).]

### <State> | <County>

##### <City/Town><Zip Code>

**<Provider Name>**

<Provider Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## Servicios y respaldos a largo plazo: [Customize per state-specific LTSS (e.g., Alimentos entregados a domicilio).]

### <State> | <County>

##### <City/Town><Zip Code>

**<Provider Name>**

<Provider Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## Servicios y respaldos a largo plazo: [Customize per state-specific LTSS (e.g., Agencias de salud en el hogar).]

### <State> | <County>

##### <City/Town><Zip Code>

**<Provider Name>**

<Provider Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## [Plans must create categories for plan providers not in the categories above.]

### <State> | <County>

##### <City/Town><Zip Code>

**<Provider Name>**

<Provider Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation]

[Indicate the provider’s cultural and linguistic capabilities. List non-English languages including ASL) spoken by the provider. List non-English languages (including ASL) offered by skilled medical interpreters on site. Indicate if translation services are available.]

[Indicate whether the provider is accepting new patients.]

[Indicate the provider’s accessibility to individuals with physical disabilities and indicate the type of accessibility (i.e., wheelchair access, accessible exam rooms, accessible equipment, etc.).]

[Indicate whether provider has special experience, skills and training, including providers with expertise in treating the demonstration population.]

[Indicate if provider is accessible by public transportation.]

[Include provider licensing information.]

[Optional: Indicate whether the provider supports electronic prescribing.]

## Farmacias

Esta parte del Directorio ofrece una lista de farmacias de la red de <plan name>. Estas farmacias de la red son farmacias que han aceptado proporcionarle a usted medicamentos de receta como miembro del plan.

[If a plan lists pharmacies in its network but outside the service area, it must use this disclaimer:] También anotamos farmacias que son parte de nuestra red, pero están fuera del área de <geographic area> donde usted vive. Usted también podrá surtir sus reetas en estas farmacias. Por favor comuníquese con <plan name> al <toll-free number>, <days and hours of operation>, para pedir información adicional.

* Los miembros de <plan name> deben usar farmacias de la red para obtener medicamentos de receta.
* Usted deberá usar farmacias de la red, excepto en situaciones de emergencia o de urgencia. Si visita una farmacia fuera de la red para buscar medicamentos de receta fuera de una emergencia, usted tendrá que pagar de su bolsillo por el servicio. Lea el Manual del miembro de <plan name> para obtener más información.
* Algunas farmacias de la red podrían no estar anotadas en este Directorio.

Podríamos haber agregado o borrado algunas farmacias de la red después de la impresión de este Directorio.

Para encontrar información actual sobre las farmacias de la red de <plan name> en su área, por favor vaya a nuestro sitio web <web address> o llame a Servicios al miembro al <toll-free number>, <days and hours of operation>. La llamada es gratuita.   
[TTY/TDD: <TTY/TDD number>.]

Para obtener una descripción completa de su cobertura de medicamentos de receta, incluyendo cómo surtir sus recetas, por favor lea el Manual del miembro y la *Lista de medicamentos cubiertos* de <plan name>. [Insert information about where members can find the List of Covered Drugs.]

## Cómo identificar a los proveedores de nuestra red

Junto con farmacias minoristas, la red de farmacias de su plan incluye:

* [Plans should insert only if they include mail-order pharmacies in their network.] Farmacias de pedidos por correo
* Farmacias de infusiones en el hogar
* Farmacias de cuidados a largo plazo (LTC)
* [Plans should insert only if they include I/T/U pharmacies in their network.] Farmacias de Indian Health Service / Tribal / Programa urbano de salud india (I/T/U)
* [Plans should insert any additional pharmacy types in their network.]
* No se requiere que usted siga visitando las mismas farmacias para surtir sus recetas. Usted puede ir a cualquiera de las farmacias de nuestra red.

## Suministro de recetas a largo plazo

[Plans should include only if they offer extended-day supplies at any pharmacy location.   
Plans should modify the language below as needed, consistent with their approved extended-day supply benefits.]

* **Programas de pedidos por correo.** Ofrecemos un programa de pedidos por correo que le permite obtener suministros de sus medicamentos de receta de hasta <number> días, enviados directamente a su hogar. Un suministro para <number> días tiene el mismo copago que el suministro para un mes.
* **Programas de farmacias minoristas de** <number> **días.** Algunas farmacias minoristas también puede ofrecer un suministro de hasta <number> días de medicamentos de medicamentos de receta cubiertos. Un suministro para <number> días tiene el mismo copago que el suministro para un mes.

## Farmacias de la red de <plan name>

**Recommended organization:** [Plans are required to include all of the following fields but have discretion regarding the organizational layout used.]

1. **Tipo de Farmacia** [del plan, de pedidos por correo, de infusión en el hogar, I/T/U]
2. **Estado** [Include only if Directory includes multiple states.]
3. **Condado** [List alphabetically.]
4. **Ciudad** [List alphabetically.]
5. **Barrio, Código postal** [Optional: For larger cities, pharmacies may be further subdivided by zip code or neighborhood.]
6. **Farmacia** [List alphabetically.]

[**Note**: Plans must indicate how types of pharmacies can be identified and located relative to organizational format.]

[**Note:** Plans must indicate when a pharmacy is not available to all members. If symbols are used, a legend must be provided.]

## Farmacias minoristas y de cadena

### <State> | <County>

##### <City/Town><Zip Code>

**<Pharmacy Name>**

<Pharmacy Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[*Include days and hours of operation*] [***Note:*** *Indicate if a pharmacy is open 7 days per week and/or 24 hours per day. You may indicate special services/hours of operation with symbols, although text is preferred. If symbols are used, a legend must be provided. For example, you may use a clock to indicate that a pharmacy is open 24 hours per day. However, it is easier for readers if the Directory simply states, “*Abierta las 24 horas*.”*]

[*Optional:* <Special Services:>] [***Note:*** *Examples of special services include Home Delivery, Drive Thru, Compounds Prepared.*]

[*Indicate whether the pharmacy provides an extended day supply of medications.*]

[Optional: Indicate whether the pharmacy supports electronic prescribing.]

[***Note:*** *Plans are expected to create one alphabetical list integrating both retail and chain pharmacies, but the information supplied may vary for retail versus chain pharmacies. Plans are required to provide the address and phone number for independent (non-chain) pharmacies. For chain pharmacies only, in lieu of providing addresses for all locations, plans may provide a toll-free customer service number and a TTY/TDD number that an enrollee can call to get the locations and phone numbers of the chain pharmacies nearest their home. If the chain pharmacy does not have a toll-free number, plans should include a central number for the pharmacy chain. If the chain pharmacy does not have a central number for enrollees to call, then plans must list each chain pharmacy and phone number in the Directory. If the chain pharmacy does not have a TTY/TDD number, plans are instructed to list the TRS Relay number 711. Plans should not list their own Member Services number as a pharmacy phone number or TTY/TDD number.*]

## [Include if applicable:] Farmacias de pedido por correo

Usted puede recibir medicamentos de receta enviados a su hogar a través de nuestro programa de pedidos por correo de nuestra red, [*plans may insert:* llamado <name of program>]. [*Plans whose network mail order services provide automated delivery, insert the following sentence*: También tiene la opción de inscribirse para entregas automáticas de pedidos por correo [*plans may insert*: a través de nuestro <name of program>].] [*Plans have the option to insert either “laborables” or “calendario” or neither in front of “días” in the following sentence:*] Generalmente, usted debe esperar recibir sus medicamentos de receta [*insert as applicable*: dentro de <number> días **or** de <number> a <number> días] desde el momento en que la farmacia de pedidos por correo recibe su pedido. Si no recibe sus medicamentos en ese plazo, por favor comuníquese con nosotros al <toll-free number>. [TTY/TDD: <phone number>.]

### <State> | <County>

##### <City/Town><Zip Code>

**<Pharmacy Name>**

<Toll-free number>  
<TTY/TDD number>

[Optional: Web and e-mail addresses]

[*Include* *days and hours of operation*] [***Note:*** *Indicate if a pharmacy is open 7 days per week and/or 24 hours per day. You may indicate special services/hours of operation with symbols, although text is preferred. If symbols are used, a legend must be provided. For example, you may use a clock to indicate that a pharmacy is open 24 hours per day. However, it is easier for readers if the Directory simply states, “*Abierta las 24 horas*.”*]

[*Optional:* <Special Services:>] [***Note:*** *Examples of special services include Home Delivery, Drive Thru, Compounds Prepared.*]

[*Optional: Indicate whether the pharmacy provides an extended day supply of medications.*]

[Optional: Indicate whether the pharmacy supports electronic prescribing.]

## Farmacias de infusiones en el hogar

[**Note:** Plans should provide any additional information on home infusion pharmacy services in their plan and how enrollees can get more information.]

### <State> | <County>

##### <City/Town><Zip Code>

**<Pharmacy Name>**

<Pharmacy Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[*Include* *days and hours of operation*] [***Note:*** *Indicate if a pharmacy is open 7 days per week and/or 24 hours per day. You may indicate special services/hours of operation with symbols, although text is preferred. If symbols are used, a legend must be provided. For example, you may use a clock to indicate that a pharmacy is open 24 hours per day. However, it is easier for readers if the Directory simply states, “Abierta las 24 horas.”*]

[*Optional:* <Special Services:>] [***Note:*** *Examples of special services include Home Delivery, Drive Thru, Compounds Prepared.*]

[*Optional: Indicate whether the pharmacy provides an extended day supply of medications.*]

[Optional: Indicate whether the pharmacy supports electronic prescribing.]

## Farmacias de cuidados a largo plazo

Los residentes de una institución de cuidados a largo plazo, como un hogar para personas mayores, pueden acceder a sus medicamentos de receta cubiertos por <plan name> a través de la farmacia de la institución o de otra farmacia de la red.

[**Note:** Plans should provide any additional information on long-term care pharmacy services in their network and how enrollees can get more information.]

### <State> | <County>

##### <City/Town><Zip Code>

**<Pharmacy/Long-Term Facility Name>**

<Pharmacy/Long-Term Facility Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[*Include* *days and hours of operation*] [***Note:*** *Indicate if a pharmacy is open 7 days per week and/or 24 hours per day. You may indicate special services/hours of operation with symbols, although text is preferred. If symbols are used, a legend must be provided. For example, you may use a clock to indicate that a pharmacy is open 24 hours per day. However, it is easier for readers if the Directory simply states, “Abierta las 24 horas.”*]

[*Optional:* <Special Services:>] [***Note:*** *Examples of special services include Home Delivery, Drive Thru, Compounds Prepared.*]

[*Optional: Indicate whether the pharmacy provides an extended day supply of medications.*]

[Optional: Indicate whether the pharmacy supports electronic prescribing.]

## **Indian Health Service / Tribal / Programa urbano de salud india (I/T/U) Pharmacies** [Note: This section applies only if there are ITU pharmacies in the service area.]

Sólo los indígenas americanos y los nativos de Alaska tienen acceso a las farmacias de Indian Health Service / Tribu / Programa urbano de salud india (I/T/U) a través de la red de farmacias de <plan name>. Para aquellos que no sean indígenas americanos y nativos de Alaska, es posible que puedan ir a estas farmacias bajo circunstancias limitadas (por ejemplo: emergencias).

[**Note:** Plans should provide any additional information on I/T/U pharmacy services in their network and how enrollees can get more information.]

### <State> | <County>

##### <City/Town><Zip Code>

**<Pharmacy Name>**

<Pharmacy Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation] [**Note:**Indicate if a pharmacy is open 7 days per week and/or 24 hours per day. You may indicate special services/hours of operation with symbols, although text is preferred. If symbols are used, a legend must be provided. For example, you may use a clock to indicate that a pharmacy is open 24 hours per day. However, it is easier for readers if the Directory simply states, *“Abierta las 24 horas.”*]

[*Optional:* <Special Services:>] [***Note:*** *Examples of special services include Home Delivery, Drive Thru, Compounds Prepared.*]

[Optional: Indicate whether the pharmacy provides an extended day supply of medications.]

[Optional: Indicate whether the pharmacy supports electronic prescribing.]

## Farmacias de la red fuera de <geographic area> [Plans’ inclusion of category is optional.]

Usted puede obtener sus medicamentos cubiertos en cualquiera de las farmacias de nuestra red. Esto incluye las farmacias de nuestra red fuera de su área de servicio.

### <State> | <County>

##### <City/Town><Zip Code>

**<Pharmacy Name>**

<Pharmacy Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[*Include* *days and hours of operation*] [***Note:*** *Indicate if a pharmacy is open 7 days per week and/or 24 hours per day. You may indicate special services/hours of operation with symbols, although text is preferred. If symbols are used, a legend must be provided. For example, you may use a clock to indicate that a pharmacy is open 24 hours per day. However, it is easier for readers if the Directory simply states, “Abierta las 24 horas.”*]

[*Optional:* <Special Services:>] [***Note:*** *Examples of special services include Home Delivery, Drive Thru, Compounds Prepared.*]

[*Optional: Indicate whether the pharmacy provides an extended day supply of medications.*]

[Optional: Indicate whether the pharmacy supports electronic prescribing.]

## [Optional: Create categories for additional types of network pharmacies not encompassed in the categories above.]

### <State> | <County>

##### <City/Town><Zip Code>

**<Pharmacy Name>**

<Pharmacy Street Address>  
<City, State>  
<Zip Code>

<Phone Number>

[Optional: Web and e-mail addresses]

[Include days and hours of operation] [***Note:***Indicate if a pharmacy is open 7 days per week and/or 24 hours per day. You may indicate special services/hours of operation with symbols, although text is preferred. If symbols are used, a legend must be provided. For example, you may use a clock to indicate that a pharmacy is open 24 hours per day. However, it is easier for readers if the Directory simply states, *“Abierta las 24 horas.”*]

[*Optional:* <Special Services:>] [***Note:*** *Examples of special services include Home Delivery, Drive Thru, Compounds Prepared.*]

[Optional: Indicate whether the pharmacy provides an extended day supply of medications.]

[Optional: Indicate whether the pharmacy supports electronic prescribing.]