

[2027 EOC model]

[Plans can modify the language in the EOC, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]

[PPO plans can modify the model as needed to describe our plan's rules and benefits.] [Where the model uses: medical care, medical services, or health care services, plans can revise and/or include references to long-term services and supports (LTSS) and/or home and community-based services as applicable.]

January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services and Drug coverage as a Member of *[insert 2027 plan name] [insert plan type]*

[Revise this language to reflect that the organization is providing both Medicaid- and Medicare-covered benefits, when applicable.]

[Optional: Insert member name]

[Optional: Insert member address]

This document gives the details about your Medicare *[insert if applicable: and <state-specific name for Medicaid> If the state-specific name doesn't include the word: Medicaid, plans should add: (Medicaid) after the name for this instance.]* health *[Plans can add references to other services, long-term care, and/or home and community-based services as applicable.]* and drug coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost sharing
- Our medical and drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at *[insert Member Services number]*. (TTY users call *[insert TTY number]*). Hours are *[insert days and hours of operation]*. This call is free.

This plan, *[insert 2027 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]*. When it says “plan” or “our plan,” it means *[insert 2027 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.] [Fully integrated dual eligible special needs plans, highly integrated dual eligible special needs plans, and applicable integrated plans as defined at § 422.561 must also include languages required by the Medicaid translation standard as specified through its capitated Medicaid managed care contract.] [Plans must insert language about availability of alternate formats (e.g., braille, large print, audio).]]

[Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31)(ii) and 423.2267(e)(33)(ii), plans must provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that our plan provides language assistance services and appropriate auxiliary aids and services free of charge. Our plan must provide the notice in English and at least the 15 languages most commonly spoken by people with limited English proficiency in the relevant state or states in our plan’s service area and must provide the notice in alternate formats for people with disabilities who require auxiliary aids and services to ensure effective communication.]

[Remove terms as needed to reflect plan benefits] Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

[Remove terms as needed to reflect plan benefits] Our formulary, pharmacy network, and/or provider network may change at any time. You’ll get notice about any changes that may affect you at least 30 days in advance.

[Plans can insert any state-required statements, including state-required disclaimer language, here.]

[Standardized materials must be used by all MAOs, PDPs, and Cost Plans exactly as provided, unless otherwise indicated below and/or in the instructions within the EOC.]

Permissible Alterations/Modifications or Deletions of Standardized Language:

- *Correct minor grammatical or punctuation changes, update/correct phone numbers, and/or references).*
- *Recreate graphics and/or tables, add plan logos, correct formatting (e.g., font style, margins), provided changes meet regulations at 42 C.F.R. §§ 422 Subpart V and 423 Subpart V, the CMS Medicare Communications and Marketing Guidelines (MCMG), and other CMS guidance. The standardized text must be used in the same order as the standardized material.*

- *Correct web addresses or URLs if inaccessible or broken.*
- *Delete plan instructions in blue text when populating the materials.*
- *Modify or delete, as necessary, all references under “all Plan Types” not relevant to the plan.*
- *Modify, or delete, as necessary, all references to primary care providers (PCP), referrals, etc. if the organization uses an open access model,*
- *Modify language related to network providers, as necessary, to clarify when a POS benefit may furnish coverage.*
- *Change any references to Member Services, Pharmacy Directory, Provider Directory, Membership Identification (ID) card, and Formulary to the term used by the plan*
- *Change references to TTY to TDD or TTY/TDD to reflect the correct communication technology.*
- *Delete all step therapy references if any Part B and/or Part D drugs don’t require step therapy.*
- *Remove all ANOC references for new enrollees with effective dates of January 1 and later since only the EOC must be distributed to these enrollees.*
- *Include multiple benefit packages within one EOC and clearly differentiate one from another to ensure that enrollees easily understand the information for the plan in which they are enrolled.*
- *Include multiple benefit packages for the same plan type only and all benefit packages must either offer, or not offer, Part D coverage. Examples: 1) Include all MA-only HMOs or all MA-PD HMOs in one EOC, and 2) An MA-only HMO may not be included with an MA-PD HMO, and an MA-only HMO may not be included with an MA-only or MA-PD PPO.*

Go to **Appendix A** for Operational Guidance.]

[Insert Material ID: (H, R, S, or Y) number_description of choice (M or C)]

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[Applicable integrated plans, the subset of fully integrated dual eligible special need plans (FIDE SNPs) and highly integrated dual eligible special need plans (HIDE SNPs) with exclusively aligned enrollment, are required to use Chapter 9B instead of Chapter 9A.]

[Plans should remove the corresponding letter, either "A" or "B", from whichever version of Chapter 9 our plan uses (either Chapter 9A or Chapter 9B) from the document. This includes the table of contents.]

CHAPTER 1:

Get started as a member

SECTION 1 You're a member of *[insert 2027 plan name]*

[Plans can revise this language to elaborate on the coordination between Medicare and Medicaid.]

Section 1.1 You're enrolled in *[insert 2027 plan name]*, which is a Medicare Special Needs Plan

You're covered by both Medicare and Medicaid:

- **Medicare** is 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 (kidney failure).
- **Medicaid** is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that aren't covered by Medicare.

You've chosen to get your Medicare *[insert if applicable: and Medicaid]* health care and your drug coverage through our plan, *[insert 2027 plan name]*. Our plan covers all Part A and Part B services. However, cost sharing and provider access in our plan differ from Original Medicare.

[Insert 2027 plan name] is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means benefits are designed for people with special health care needs. *[Insert 2027 plan name]* is designed for people who have Medicare and are entitled to help from Medicaid.

[Plans should revise this section to better reflect the services and costs for members.] Because you get help from Medicaid with Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance), you may pay nothing for your Medicare services. Medicaid *[insert as applicable: may also provide OR also provides]* other benefits by covering health care services *[Plans can add references to prescription drugs, long-term care and/or home and*

Chapter 1 Get started as a member

community-based services as applicable.] that aren't usually covered under Medicare. *[Plans that, per the State Medicaid Agency Contract, exclusively enroll QMBs, SLMBs, QIs, or dually eligible people with full Medicaid benefits insert: You'll also get Extra Help from Medicare to pay for the costs of your Medicare drugs.] [Other plans insert: You may also get Extra Help from Medicare to pay for the costs of your Medicare drugs.] [insert 2027 plan name]* will help you manage all these benefits, so you get the health services and payment help that you're entitled to.

[insert 2027 plan name] is run by a *[insert as applicable: private company OR non-profit organization OR government entity]*. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. Our plan also has a contract with the *[insert state]* Medicaid program to coordinate your Medicaid benefits. We're pleased to provide your Medicare *[insert if applicable: and Medicaid]* coverage, including drug coverage *[plans can add references to long-term care and/or home and community-based services as applicable]*.

Section 1.2 Legal information about the Evidence of Coverage

This *Evidence of Coverage* is part of our contract with you about how *[insert 2027 plan name]* covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs* (formulary), and any notices you get 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 the months you're enrolled in *[insert 2027 plan name]* between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of *[insert 2027 plan name]* after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

Medicare (the Centers for Medicare & Medicaid Services) and *[insert state-specific Medicaid name]* must approve *[insert 2027 plan name]*. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare and *[insert state-specific Medicaid name]* renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B

Chapter 1 Get started as a member

- You live in our geographic service area (described in Section 2.3). *[Plans with grandfathered members who were outside of area prior to January 1999, insert: If you've been a member of our plan continuously since before January 1999 and you were living outside our service area before January 1999, you're still eligible for our plan as long as you haven't moved since before January 1999.]* People who are incarcerated aren't considered to be living in the geographic service area even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States
- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

[Plans can add language regarding other eligibility requirements, such as age and/or disabilities, if applicable.] Our plan is designed to meet the needs of people who get certain Medicaid benefits. (Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be *[insert as appropriate: eligible for both Medicare and Medicaid OR eligible for Medicare and Full Medicaid Benefits OR eligible for Medicare cost-sharing help under Medicaid OR [insert language as appropriate under terms of state contract]]*.

Note: If you lose your eligibility but can reasonably be expected to regain eligibility within *[insert number 1-6. Plans can choose any length of time from one to six months for deeming continued eligibility, as long as they apply the criteria consistently across all members and fully inform members of the policy]*-month(s), then you're still eligible for membership. Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility.

Section 2.2 Medicaid

[Plans can revise this section to provide state-specific information.] Medicaid is a joint federal and state government program that helps with medical *[insert if applicable: and long-term care]* costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who's eligible, what services are covered, and the cost for services. States also can decide how to run its program as long as they follow the federal guidelines.

[Plans should include only those Medicare Savings Programs eligible for enrollment in its plan. Plans that limit enrollment to QMB+/SLMB+ can revise the QMB/SLMB bullets below to describe only QMB+/SLMB+.] In addition, Medicaid offers programs to help people pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

Chapter 1 Get started as a member

- **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+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

Section 2.3 Plan service area for *[insert 2027 plan name]*

[insert 2027 plan name] is only available to people who live in our plan service area. To stay 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 live in our 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 can 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 can insert more than one row to describe its 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 information: multi-state plans can include the following two paragraphs: We offer coverage in [insert as applicable: several OR all] states [insert if applicable: and territories]. However, there may be costs or other differences between our 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's still within our service area, you must call Member Services at [insert Member Services number] (TTY users call [insert TTY number]) to update your information. [National plans may delete the rest of this paragraph.]]

If you plan to move to a new state, you should also contact your state's Medicaid office and ask how this move will affect your Medicaid benefits. Phone numbers for Medicaid are in Chapter 2, Section 6 of this document.

Chapter 1 Get started as a member

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services *[insert Member Services number]* (TTY users call *[insert TTY number]*) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.4 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify *[insert 2027 plan name]* if you're not eligible to stay a member of our plan on this basis. *[insert 2027 plan name]* must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

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

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

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card. Sample membership card:

[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).]

DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your *[insert 2027 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 Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) right away and we'll send you a new card.

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Section 3.2 Provider Directory

[Plans with combined Provider and Pharmacy Directories can 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* *[insert direct URL to provider directory]* lists our current network providers *[insert if applicable: and durable medical equipment suppliers]*. **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 that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. *[Plans with sub-networks (e.g., limiting members to providers within its PCP's sub-network) insert a brief explanation of the additional limitations of your sub-network structure. Refer to the current Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance for guidance on sub-networks.]* If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is situations where it's unreasonable or not possible to get services in network), out-of-area dialysis services, and cases when *[insert 2027 plan name]* authorizes use of out-of-network providers.

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

[Insert as applicable: We included a copy of our Provider Directory in the envelope with this document.] [Insert as applicable: We [insert as applicable: also] included a copy of our Durable Medical Equipment Supplier Directory in the envelope with this document.] [The most recent list of providers [insert as applicable: and suppliers] on our website at [insert URL].]

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services *[insert Member Services number]* (TTY users call *[insert TTY number]*). Requested paper *Provider Directories* will be mailed to you within 3 business days.

Section 3.3 Pharmacy Directory

[Plans with combined Provider and Pharmacy Directories can 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.]

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The *Pharmacy Directory* *[insert direct URL to pharmacy directory]* lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

[Insert if plan has pharmacies that offer preferred cost sharing in its network: The Pharmacy Directory also shows which 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 a *Pharmacy Directory*, you can ask for a copy from Member Services *[insert Member Services number]* (TTY users call *[insert TTY number]*). You can also find this information on our website at *[insert URL]*. *[Plans can add detail describing additional information about network pharmacies available from Member Services or on the website.]*

Section 3.4 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit in *[insert 2027 plan name]*. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved the *[insert 2027 plan name]* Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. *[Insert if applicable: The Drug List includes information for the covered drugs most commonly used by our members. However, we also cover additional drugs that aren't included in the Drug List. If one of your drugs isn't listed in the Drug List, visit our website or call Member Services at [insert Member Services number] (TTY users call [insert TTY number]) to find out if we cover it.]* To get the most complete and current information about which drugs are covered, visit *[insert direct URL for drug list]* or call Member Services *[insert Member Services number]* (TTY users call *[insert TTY number]*).

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* * Your premium can be higher <i>[Plans with \$0 premium should not include: or lower]</i> than this amount. Go to Section 4.1 <i>[edit section number as needed]</i> for details.	<i>[Insert 2027 premium amount]</i>
<i>[Plans with no deductible can delete this row.]</i> Deductible	<i>[Insert 2027 deductible amount]</i> <i>[If an amount other than \$0, add: except for insulin furnished through an item of durable medical equipment.]</i> <i>[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0.]</i>

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Your Costs in 2027	
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out-of-pocket for covered <i>[insert if applicable: Part A and Part B]</i> services. (Go to Chapter 4 Section 1 <i>[edit section number as needed]</i> for details.)	<i>[Insert 2027 MOOP amount]</i> <i>[Plans that only include members who don't pay Parts A and B service cost sharing insert: You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.]</i> <i>[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.]</i>
Primary care office visits	<i>[Insert 2027 cost sharing for PCPs] per visit</i> <i>[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.]</i>

	Your Costs in 2027
Specialist office visits	<i>[Insert 2027 cost sharing for specialists] per visit</i> <i>[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.]</i>
Inpatient hospital stays	<i>[Insert 2027 cost sharing]</i> <i>[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0.]</i>
Part D drug coverage deductible (Go to Chapter 6 Section 4 <i>[edit section number as needed]</i> for details.)	<i>[Insert 2027 deductible amount]</i> <i>[If an amount other than \$0, add: except for covered insulin products and most adult Part D vaccines.]</i>

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Part D drug coverage

(Go to Chapter 6 *[edit chapter number as needed]* for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)

Your Costs in 2027

[Copayment/ Coinsurance as applicable] during the Initial Coverage Stage:

Drug Tier 1: *[Insert 2027 cost sharing]*
[Insert if insulin cost sharing differs from cost sharing for other drugs on the same tier: You pay \$[xx] per month supply of each covered insulin product on this tier.]

[Repeat for all drug tiers.]

Catastrophic Coverage Stage:

[Plans that don't cover excluded drugs under an enhanced benefit, OR plans that do cover excluded drugs under an enhanced benefit but with the same cost sharing as covered Part D drugs in this stage, insert the following: During this payment stage, you pay nothing for your covered Part D drugs. [insert if applicable: and for excluded drugs that are covered under our enhanced benefit].]

[Plans that cover excluded drugs under an enhanced benefit with cost sharing in this stage, insert the following: During this payment stage, you pay nothing for your covered Part D drugs.]

You may have cost sharing for drugs that are covered under our enhanced benefit.]

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[Delete Optional Supplemental Benefit Premium bullet if our plan doesn't offer optional supplemental benefits. Renumber remaining sections as appropriate. Plans with \$0 cost sharing can remove the "Medicare Prescription Payment Plan Amount (Section 4.6)" bullet.]

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)
- Part D Late Enrollment Penalty (Section 4.4)
- Income Related Monthly Adjusted Amount (Section 4.5)
- Medicare Prescription Payment Plan Amount (Section 4.6)

Section 4.1 Plan premium

[If applicable, plans should revise this section to indicate that our plan premium is paid on behalf of members (e.g., by Extra Help, Medicaid).]

As a member of our plan, you pay a monthly plan premium. *[Select one of the following: For 2027, the monthly plan premium for [insert 2027 plan name] is [insert monthly plan 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 offer in the service area. OR The monthly plan premium amount for [insert 2027 plan name] is listed in [describe attachment].] [Plans can insert a list or table with the state/region and monthly plan premium amount for each area included within the EOC. Plans can also include premium(s) in an attachment to the EOC.]*

[Plans with no premium should replace the preceding paragraph with: You don't pay a separate monthly plan premium for [insert 2027 plan name].]

If you *already* get 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 document, 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. *[Plans may indicate LIS Rider mail date.]* If you don't have this insert, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) and ask for the *LIS Rider*.

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In some situations, our plan premium could be less.

[Plans with no monthly plan 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.] Learn more about [insert as applicable: these programs OR this program] in Chapter 2, Section 7. If you qualify, enrolling in one of these programs might lower your monthly plan premium.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2027* handbook in the section called *2027 Medicare Cost*. Download a copy from the Medicare website (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

[Plans that don't have any members paying Medicare premiums or plans whose members must pay the full part B premium should modify this section.]

*[Plans with no monthly plan premium, omit: In addition to paying the monthly plan premium,] some members are required to pay other Medicare premiums. As explained in Section 2 above to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most *[insert 2027 plan name]* members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and Part B premium.*

If Medicaid isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called *optional supplemental benefits*, you pay an additional premium each month for these extra benefits. Go to Chapter 4, Section 2.1 for

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details. *[If our plan describes optional supplemental benefits within Chapter 4, then our plan must include the premium amounts for those benefits in this section.]*

[Delete Chapter 1, Section 4.3 if our plan doesn't offer optional supplemental benefits. Renummer remaining sections as appropriate.]

Section 4.4 Part D Late Enrollment Penalty

Because you're dually-eligible, the LEP doesn't apply as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable 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 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'll have to pay this penalty for as long as you have Part D coverage.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or a newsletter from that plan. Keep this information, because you may need it if you join a Medicare drug plan later.
 - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.
 - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's 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 you did not have creditable drug coverage, if the break in coverage was 63 days or more. The

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penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.

- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). *[Insert EITHER: For 2027, this average premium amount is \$[insert 2027 national base beneficiary premium] OR For 2026 this average premium amount was \$[insert 2026 national base beneficiary premium]. This amount may change for 2027.]*
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round 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 plan premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year**, because the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, 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 you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

*[Insert the following text if our plan disenrolls for failure to pay premiums: **Important:** Don't 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 our plan premiums.]*

Section 4.5 Income Related Monthly Adjustment Amount

If you lose eligibility for this plan because of changes income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is

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above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit www.Medicare.gov/health-drug-plans/part-d/basics/costs.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. 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 our 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'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 4.6 Medicare Prescription Payment Plan Amount

[Plans with \$0 cost sharing for Part D should delete this section.]

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay our plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay our plan premium

[Plans indicating in Section 4.1 that there's no monthly MA or enhanced/optional supplemental benefit premium should delete this section.]

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

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Option 1: Pay by check

[Insert plan specifics regarding premium payment intervals (e.g., monthly, quarterly- 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 our plan and not CMS nor HHS. If our plan uses coupon books, explain when they will get 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 premium/penalty payment options. Or delete this option.]

Include specific 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 our plan). Insert information on the frequency of automatic deductions (e.g., monthly, quarterly – 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. 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]*: Have our plan premium deducted from your monthly Social Security check

Changing the way you pay your premium. If you decide to change how you pay your premium, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure our plan premium is paid on time. To change your payment method, *[Plans must indicate how the member can change their selected payment method]*.

If you have trouble paying *[plans with a premium insert: our plan premium]*

[Plans that don't disenroll members for non-payment can modify this section as needed.]

[Plans that don't have a plan premium or a \$0 premium can modify this section as needed.]

[Plans with a premium insert: Our plan premium] payment is due in our office by the *[insert day of the month]*. If we don't get your payment by the *[insert day of the month]*, we'll send you

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a notice letting you know our plan membership will end if we don't get your *[plans with a premium insert: premium]* payment within *[insert length of plan grace period]*.

If you have trouble paying *[plans with a premium insert: your premium]* on time, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) to see if we can direct you to programs that will help *[plans with a premium insert: with our plan premium]*.

If we end your membership because you didn't pay *[plans with a premium insert: our plan premium]*, you'll have health coverage under Original Medicare. As long as you're getting Extra Help with your prescription drug costs, you'll continue to have Part D drug coverage. Medicare will enroll you into a new prescription drug plan for your Part D coverage.

[Insert if applicable: At the time we end your membership, you may still owe us for unpaid [plans with a premium insert: premiums]. [Insert one or both statements as applicable for our plan: We have the right to pursue collection of the amount you owe. AND/OR If you want to enroll again in our plan (or another plan that we offer) in the future, you'll need to pay the amount you owe before you can enroll.]]

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control and that made you unable to pay your *[plans with a premium insert: plan premium]* within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 9 to learn how to make a complaint or call us at *[insert phone number]* between *[insert hours of operation]*. TTY users call *[insert TTY number]*. You must make your complaint no later than 60 calendar days after the date your membership ends.

Section 5.2 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September, and the new premium will take effect on January 1.

If you become eligible for Extra Help or lose your eligibility for Extra Help during the year, the part of our plan premium you have to pay may change. If you qualify for Extra Help with your drug coverage costs, Extra Help pays part of your monthly plan premium. If you lose eligibility for Extra Help during the year, you'll need to start paying the full monthly plan premium. Find out more about Extra Help in Chapter 2, Section 7.

[Plans with no premium replace the previous paragraph with the following: However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty. This could happen if you become eligible for Extra Help or lose your eligibility for Extra Help during the year.]

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

Find out more about Extra Help in Chapter 2, Section 7.]

SECTION 6 Keep our plan membership record up to date

[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 phone number. It shows your specific plan coverage *[insert as appropriate: including your Primary Care Provider/Medical Group/IPA]*.

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services *[insert Member Services number]* (TTY users call *[insert TTY number]*). *[Plans that allow members to update this information on-line can describe that option here.]*

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

[Plans can instruct members how to keep their Medicaid information up to date as directed by the state.]

SECTION 7 How other insurance works with our plan

[Plans collecting information by phone revise heading and section as needed to reflect process.]

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services *[insert Member Services number]* (TTY users call *[insert TTY number]*). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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) are 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 has more than 100 employees.
 - If you're over 65 and you (or your spouse or domestic partner) are 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 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.

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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 and/or employer group health plans have paid.

CHAPTER 2:

Phone numbers and resources

SECTION 1 *[Insert 2027 plan name]* contacts

For help with claims, billing, or member card questions, call or write to *[insert 2027 plan name]* Member Services. We'll be happy to help you.

Member Services – Contact Information

Call	<i>[Insert phone number(s)]</i> Calls to this number are free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i> Member Services <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i>) also has free language interpreter services for non-English speakers.
TTY	<i>[Insert number]</i> <i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.]</i> Calls to this number are free. <i>[Insert days and hours of operation.]</i>
Fax	<i>[Optional: insert fax number]</i>
Write	<i>[Insert address]</i> [Note: <i>plans can add email addresses here.</i>
Website	<i>[Insert URL]</i>

[Note: If our plan uses the same contact information for the Part C and Part D issues indicated below, you can combine the appropriate sections and revise the section titles and paragraphs as needed.]

Chapter 2 Phone numbers and resources**How to ask for a coverage decision or appeal about your medical care**

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

[If our plan has different phone numbers for coverage decisions and appeals or for medical care and prescription drugs, our plan should duplicate the chart as necessary, labeling appropriately.]

Coverage Decisions and Appeals for Medical Care or Part D drugs – Contact Information

Call	<i>[Insert phone number]</i> Calls to this number are <i>[insert if applicable: not]</i> free. <i>[Insert days and hours of operation]</i> [Note: You can 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	<i>[Insert number]</i> <i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.]</i> Calls to this number are free. <i>[Insert days and hours of operation]</i> [Note: If you have a different TTY number for accepting expedited organization determinations, also include that number here.]
Fax	<i>[Optional: insert fax number]</i> [Note: If you have a different fax number for accepting expedited organization determinations, also include that number here.]
Write	<i>[Insert address]</i> [Note: If you have a different address for accepting expedited organization determinations, also include that address here.] [Note: plans can add email addresses here.]
Website	<i>[Optional: Insert URL]</i>

Chapter 2 Phone numbers and resources**How to make a complaint about your medical care**

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

[If plan has different numbers for complaints regarding providers and pharmacies, duplicate the chart below to account for the different numbers.]

Complaints about Medical Care – Contact Information

Call	<p><i>[Insert phone number]</i></p> <p>Calls to this number are <i>[insert if applicable: not]</i> free. <i>[Insert days and hours of operation]</i> Note: You can also include reference to 24-hour lines here.] Note: If you have a different number for accepting expedited grievances, also include that number here.]</p>
TTY	<p><i>[Insert number]</i></p> <p><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.]</i></p> <p>Calls to this number are free. <i>[Insert days and hours of operation]</i> Note: If you have a different TTY number for accepting expedited grievances, also include that number here.]</p>
Fax	<i>[Optional: insert fax number]</i> Note: If you have a different fax number for accepting expedited grievances, also include that number here.]
Write	<p><i>[Insert address]</i> Note: If you have a different address for accepting expedited grievances, also include that address here.]</p> <p>Note: plans can add email addresses here.]</p>
Medicare website	To submit a complaint about <i>[insert 2027 plan name]</i> directly to Medicare, go to www.Medicare.gov/my/medicare-complaint .

Chapter 2 Phone numbers and resources**How to ask us to pay *[insert if plan has cost sharing: our share of]* the cost for medical care or a drug you got**

[Plans with an arrangement with the state can add language to reflect that the organization isn't allowed to reimburse members for Medicaid covered benefits. Plans adding this language should include reference to our plan's Member Services phone number.]

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

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

Payment Requests – Contact Information

Call	<p><i>[Optional: Insert phone number and days and hours of operation]</i></p> <p>[Note: You are required to accept payment requests in writing and can choose to also accept payment requests by phone.]</p> <p>Calls to this number are <i>[insert if applicable: not]</i> free.</p>
TTY	<p><i>[Optional: Insert number]</i> [Note: You are required to accept payment requests in writing and can choose to also accept payment requests by phone.]</p> <p><i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.]</i></p> <p>Calls to this number are free. <i>[Insert days and hours of operation]</i></p>
Fax	<p><i>[Optional: Insert fax number]</i> [Note: You are required to accept payment requests in writing and can choose to also accept payment requests by fax.]</p>
Write	<p><i>[Insert address]</i></p> <p>[Note: plans can add email addresses here.]</p>
Website	<p><i>[Insert URL]</i></p>

Chapter 2 Phone numbers and resources

SECTION 2 Get help from Medicare

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 (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information

Call	1-800-MEDICARE (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 hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone .
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.Medicare.gov <ul style="list-style-type: none">• Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.• Find Medicare-participating doctors or other health care providers and suppliers.• Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits).• Get Medicare appeals information and forms.• Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.• Look up helpful websites and phone numbers.

Chapter 2 Phone numbers and resources

You can also visit www.Medicare.gov to tell Medicare about any complaints you have about *[insert 2027 plan name]*.

To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In *[insert state]*, the SHIP is called *[insert state-specific SHIP name]*.

[Insert state-specific SHIP name] is an independent state program (not connected with any insurance company or health plan) 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 understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. *[Insert state-specific SHIP name]* counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

[Insert state-specific SHIP name] [If the SHIP's name doesn't include the name of the state, add: ([insert state name] SHIP)] – Contact Information

Call	<i>[Insert phone number(s)]</i>
TTY	<i>[Insert number, if available. Or delete this row.]</i>
	<i>[Insert if the SHIP uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.]</i>
Write	<i>[Insert address]</i>
	<i>[Note: Plans can add email addresses here.]</i>
Website	<i>[Insert URL]</i>

SECTION 4 Quality Improvement Organization (QIO)

[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.]

A designated Quality Improvement Organization (QIO) serves people with Medicare in 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 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's not connected with our plan.

Contact *[insert state-specific QIO name]* in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- 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 is ending too soon.

[Insert state-specific QIO name] [If the QIO's name doesn't include the name of the state, add: ([insert state name]'s Quality Improvement Organization)] – Contact Information

Call	<i>[Insert phone number(s) and days and hours of operation]</i>
TTY	<i>[Insert number, if available. Or delete this row.]</i> <i>[Insert if the QIO uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.]</i>
Write	<i>[Insert address]</i> <i>[Note: Plans can add email addresses here.]</i>
Website	<i>[Insert URL]</i>

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SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for 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, contact Social Security to let them know.

Social Security– Contact Information

Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. 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 8 am to 7 pm, Monday through Friday.
Website	www.SSA.gov

SECTION 6 Medicaid

[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 must adapt this generic discussion of Medicaid to reflect the name or features of the Medicaid program in our plan’s state or states.]

[Plans should modify this section to include additional language explaining that members are dually enrolled with both Medicare and Medicaid.]

Chapter 2 Phone numbers and resources

[Organizations that offer both D-SNP products and Medicaid managed care plans can describe the Medicaid managed care program under which the organization contracts with the state Medicaid agency and should also describe its specific benefits.]

[If there are two different agencies handling eligibility and coverage/services, our plan should include both and clarify the role of each.]

[Plans must, as appropriate, include additional telephone numbers and days and hours of operation, for Medicaid program help, e.g., the telephone number for the state Ombudsman.]

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.

[Plans should include and describe below only those Medicare Savings Programs eligible for enrollment in its plan.]

If you have questions about the help you get from Medicaid, contact *[insert state-specific Medicaid agency]*. *[If applicable, plans can also inform members within this section that they can get information about Medicaid from county resource centers and indicate where members can find contact information for these centers.]*

***[Insert state-specific Medicaid agency]* [If the agency's name doesn't include the name of the state, add: (*[insert state name]*'s Medicaid program)] – Contact Information**

Call	<i>[Insert phone number(s) and days and hours of operation]</i>
TTY	<i>[Insert number, if available. Or delete this row.]</i> <i>[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 hearing or speaking.]</i>
Write	<i>[Insert address]</i> <i>[Note: Plans can add email addresses here.]</i>
Website	<i>[Insert URL]</i>

The *[insert state-specific name for ombudsman program]* helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

***[Insert state-specific name for ombudsman program]* – Contact Information**

Call	<i>[Insert phone number(s) and days and hours of operation]</i>
TTY	<i>[Insert number, if available. Or delete this row.]</i>

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	<i>[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 hearing or speaking.]</i>
Write	<i>[Insert address]</i> <i>[Note: Plans can add email addresses here.]</i>
Website	<i>[Insert URL]</i>

The *[insert state-specific name for LTC ombudsman program]* helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

***[insert state-specific name for LTC ombudsman program]* – Contact Information**

Call	<i>[Insert phone number(s) and days and hours of operation]</i>
TTY	<i>[Insert number, if available. Or delete this row.]</i> <i>[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 hearing or speaking.]</i>
Write	<i>[Insert address]</i> <i>[Note: Plans can add email addresses here.]</i>
Website	<i>[Insert URL]</i>

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (www.Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

[Plans that, per the State Medicaid Agency Contract, exclusively enroll QMBs, SLMBs, QIs, or dual eligible people with full Medicaid benefits insert this language: Because you're eligible for Medicaid, you qualify for and get Extra Help from Medicare to pay for your prescription drug plan costs. You don't need to do anything further to get this Extra Help.]

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048;

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- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users call 1-800-325-0778; or
- Your State Medicaid Office at *[insert state-specific Medicaid agency number]*.

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of your proper copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- *[Insert plan's process for allowing members to ask for help to get the best available evidence, and for providing this evidence.]*
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) if you have questions.

[Other plans should use this language: Most of our members qualify for and are already getting Extra Help from Medicare to pay for their prescription drug plan costs.]

[Plans without an SPAP in its state(s) or in states where the SPAP excludes enrollment of dual eligible people, should delete the following section.]

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

Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

[Insert State-specific SPAP information.]

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the *[insert State-specific ADAP information]*.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and

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uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call *[insert State-specific ADAP contact information]*.

State Pharmaceutical Assistance Programs

[Plans without an SPAP in its state(s) or in states where the SPAP excludes enrollment of dual eligible people, 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 can, as appropriate, include additional telephone numbers for Medicaid program help, e.g., the telephone number for the state Ombudsman.]

Many states have State Pharmaceutical Assistance Programs that help 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] [Multiple 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]*.*

[Insert state-specific SPAP name] [If the SPAP's name doesn't include the name of the state, add: (*[insert state name]*'s State Pharmaceutical Assistance Program)] – Contact Information

Call	<i>[Insert phone number(s) and days and hours of operation]</i>
TTY	<i>[Insert number, if available. Or delete this row.]</i> <i>[Insert if the SPAP uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.]</i>
Write	<i>[Insert address]</i> <i>[Note: Plans can add email addresses here.]</i>
Website	<i>[Insert URL]</i>

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[Plans with \$0 cost sharing for Part D should delete the below information on the Medicare Prescription Payment Plan.]

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027.** Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) or visit www.Medicare.gov.

Medicare Prescription Payment Plan – Contact Information

Call	<i>[Insert phone number(s)]</i> Calls to this number are free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i> Member Services <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i>) also has free language interpreter services for non-English speakers.
TTY	<i>[Insert number]</i> <i>[Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.]</i> Calls to this number are free. <i>[Insert days and hours of operation.]</i>
Fax	<i>[Optional: insert fax number]</i>
Write	<i>[Insert address]</i> [Note: <i>Plans can add email addresses here.</i>
Website	<i>[Insert URL]</i>

Chapter 2 Phone numbers and resources**SECTION 8 Railroad Retirement Board (RRB)**

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 get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information

Call	<p>1-877-772-5772</p> <p>Calls to this number are free.</p> <p>Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday.</p> <p>Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.</p>
TTY	<p>1-312-751-4701</p> <p>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.</p> <p>Calls to this number aren't free.</p>
Website	https://RRB.gov

SECTION 9 If you have group insurance or other health insurance from an employer

[Plans can, as appropriate, delete this section since members covered under employer groups aren't eligible to participate in dual eligible SNPs in some states.]

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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

SECTION 10 Get help from *[insert name]*

[Plans can insert this section to provide additional information resources, such as county resource centers or Area Agencies on Aging, editing the section title as necessary.]

CHAPTER 3:

Using our plan for your medical *[insert if applicable: and other covered]* services

SECTION 1 How to get medical care *[insert if applicable: and other services]* as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care *[insert if applicable: and other services]* covered. For details on what medical care *[insert as applicable: is OR and other services]* our plan covers *[insert if plan has cost sharing: and how much you pay when you get care]*, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **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.
- **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 *[insert if plan has cost sharing: and your cost-sharing amount]* as payment in full. We 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 *[insert applicable: pay nothing or pay only your share of the cost or pay nothing or only your share of the cost]* for covered services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care *[insert if applicable: and other services]* to be covered by our plan

As a Medicare *[insert if applicable: and Medicaid]* health plan, *[insert 2027 plan name]* must cover all services covered by Original Medicare *[insert if applicable: and may offer other services in addition to those covered under Original Medicare [reference appropriate section.]]*

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

[Insert 2027 plan name] will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- *[Plans can omit or edit the PCP-related bullets as necessary.]* **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
 - In most situations, *[insert as applicable: your network PCP OR our plan]* must give you approval in advance (a referral) before you can use other providers in our plan’s network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
 - You don’t need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- *[Plans with a POS option can edit the network provider bullets as necessary.]* **You must get your care from a network provider** (see Section 2). In most cases, care you get from an out-of-network provider (a provider who’s not part of our plan’s network) won’t be covered. This means that you have to pay the provider in full for services you get. Here are 3 exceptions:
 - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
 - If you need medical care that Medicare *[insert if applicable: or Medicaid]* requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. *[Plans can specify if authorization should be obtained from our plan prior to seeking care.]* In this situation, we’ll cover these services *[insert as applicable: as if you got the care from a network provider OR at no cost to you]*. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
 - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you’re temporarily outside our plan’s service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you’re outside our plan’s service area and get dialysis

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care *[insert if applicable: and other services]*

Section 2.1 You *[insert as applicable: may OR must]* choose a Primary Care Provider (PCP) to provide and oversee your care

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

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

[Plans should describe the following in the context of its plans:]

- *What is a PCP?*
- *What types of providers may act as a PCP?*
- *Explain the role of a PCP in our plan.*
- *What is the role of the PCP in coordinating covered services?*
- *What is the role of the PCP in making decisions about or getting a prior authorization (PA), if applicable?*

How to choose a PCP

[Plans should describe how to choose a PCP.]

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP. *[Explain if the member changes their PCP this can result in being limited to specific specialists or hospitals to which that PCP refers (i.e., sub-network, referral circles). Also noted in Section 2.3.]*

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

[Plans should describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of request, etc.).]

[Plans that are obligated under state Medicaid programs to have a transition benefit when a doctor leaves a plan, can discuss that benefit here.]

Section 2.2 Medical care *[insert if applicable: and other services]* you can get without a PCP referral

[Note: Insert this section only if plans use PCPs or require referrals to network providers.]

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

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams *[insert if applicable: as long as you get them from a network provider]*
- Flu shots, COVID-19 vaccines, *[insert if applicable: Hepatitis B vaccines, and pneumonia vaccines]* *[insert if appropriate: as long as you get them from a network provider]*
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- *[Plans should add additional bullets as appropriate.]*

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

Section 2.3 How to get care from specialists and other network providers

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

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

[Plans should describe how members access specialists and other network providers, including:

- *What is the role (if any) of the PCP in referring members to specialists and other providers?*
- *Include an explanation of the process for getting a PA, including who makes the PA decision (e.g., our plan, PCP, another entity) and who is responsible for getting a PA (e.g., PCP, member). Refer members to Chapter 4, Section 2.1 for information about which services require PA.*
- *Explain if the selection of a PCP results in being limited to specific specialists or hospitals to which that PCP refers, i.e. sub-network, referral circles.]*

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
 - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. *[Plans should indicate if prior authorization is needed.]*
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

Section 2.4 How to get care from out-of-network providers

[Plans with a POS option: Describe POS option here. Tell members under what circumstances they can get services from out-of-network providers and what restrictions apply. General information (no specific dollar amounts) about cost sharing applicable to the use of out-of-network providers in HMO/POS plans should be inserted here, with reference to the Medical Benefits Chart where detailed information can be found.]

[Plans without a POS option: Tell members under what circumstances they can get services from out-of-network providers (e.g., when providers of specialized services aren't available in network). Describe the process for getting authorization, including who is responsible for getting authorization.] [Note: members are entitled to get services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover dialysis services for ESRD members who have traveled outside our plan's service area and aren't able to access contracted ESRD providers.]

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical 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

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

immediate medical attention to prevent your loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting 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 don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network *[Plans can modify this sentence to identify whether this coverage is within the U.S. or world-wide emergency/urgent coverage].*
- *[Plans add if applicable: As soon as possible, make sure 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 of our plan membership card).]]*

Covered services in a medical emergency

[Plans that cover emergency medical care outside the United States or its territories through Medicaid can describe this coverage based on the State Medicaid program coverage area. Plans must also include language emphasizing that Medicare doesn't provide coverage for emergency medical care outside the United States and its territories.]

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable and when the medical emergency is over.

[Plans can modify this paragraph as needed to address the post-stabilization care for our plan.]

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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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 wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

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

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

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

[Plans that cover urgently needed services outside the United States or its territories through Medicaid can describe this coverage based on the State Medicaid program coverage area. Plans must also include language emphasizing that Medicare doesn't provide coverage for emergency medical care outside the United States and its territories.]

[Insert if applicable: Plans without world-wide emergency/urgent coverage as a supplemental benefit: Our plan doesn't cover emergency services, urgently needed services, or any other services you get outside of the United States and its territories.]

*[Insert if applicable: Plans with world-wide emergency/urgent coverage as a supplemental benefit: Our plan covers worldwide *[Insert as applicable: emergency and urgent care OR emergency OR urgent care]* services outside the United States under the following circumstances *[insert details.]*]*

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

Section 3.3 Get 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're still entitled to care from our plan.

Visit *[insert website]* for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

SECTION 4 What if you're billed directly for the full cost of covered services?

[Plans with an arrangement with the state can add language to reflect that the organization isn't allowed to reimburse members for Medicaid covered benefits.]

[Insert as applicable: If you paid for your covered services OR If you paid more than our plan cost sharing for covered services], or if you get a bill for *[plans with cost sharing insert: the full cost of]* covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan

[Plans with an arrangement with the state can add language to reflect that the organization isn't allowed to reimburse members for Medicaid covered benefits.]

[Plans should revise this section as necessary to instruct members that before paying for the cost of the service, members should check with our plan if the service is covered by Medicaid.]

[Insert 2027 plan name] covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, or you get services out-of-network without authorization, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use 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.]*

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

[If applicable, plans should revise this section as needed to describe Medicaid's role in providing coverage and payment for clinical research studies.]

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. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us that you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us *[Plans that don't use PCPs can delete the rest of this sentence.]* or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

[For plans that offer its own studies, insert the paragraph: Our plan also covers some clinical research studies. For these studies, we have to approve your participation. Participation in the clinical research study is voluntary.]

If you participate in a study not approved by Medicare *[plans that conduct or cover clinical trials that aren't approved by Medicare insert: or our plan]*, you'll be responsible for paying all costs for your participation in the study.

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

Section 5.2 Who pays for services in a clinical research study

[If applicable, plans should revise this section as needed to describe Medicaid's role in providing coverage and payment for clinical research studies.]

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get 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.

[Zero cost-share plans, replace the rest of this paragraph and the example below with: After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you'll pay nothing for the covered services you get in the clinical research study.] After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs \$100 as part of the research study. Your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan. In this case, Original Medicare would pay \$80 for the test, and you would pay the \$20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you \$10. This makes your net payment for the test \$10, the same amount you'd pay under our plan's benefits.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

Section 6.1 A religious non-medical health care institution

[If applicable, plans should revise this section as needed to describe Medicaid's role in providing care in religious non-medical health care institutions.]

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'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

[If applicable, plans should revise this section as needed to describe Medicaid's role in providing care in religious non-medical health care institutions.]

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that's **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *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:

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution 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 get 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're admitted to the facility, or your stay won't be covered.

[Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Medical 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 You won't own some 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. If applicable, plans should also explain Medicaid coverage of DME and the coordination, if any, with plan coverage of DME.]

Durable medical equipment (DME) includes items like 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 members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME 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 2027 plan name]*, you *[insert if our plan sometimes allows ownership: usually]* won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. *[Insert if our plan sometimes allows transfer of ownership for items other than prosthetics: Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) for more information.]*

Chapter 3 Using our plan for your medical *[insert if applicable: and other covered]* services

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. *[If our plan allows ownership insert: You'll have to make 13 payments to our plan before owning the item.] [Plans that want to honor former payments should state so.]*

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage *[insert 2027 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 2027 plan name]* or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart

(what's covered *[plans with cost sharing insert: and what you pay]*)

[Plans can add a discussion to this chapter if its organization provides or arranges for benefits under Medicaid.]

SECTION 1 Understanding *[insert if plan has cost sharing: your out-of-pocket costs for]* covered services

The Medical Benefits Chart lists your covered services *[insert if plan has cost sharing: and shows how much you pay for each covered service]* as a member of *[insert 2027 plan name]*. This section also gives information about medical services that aren't covered. *[Insert if applicable: and explains limits on certain services.] [If applicable, you can mention other places where benefits, limitations, and exclusions are described, such as optional additional benefits, or addenda.]*

Section 1.1 Out-of-pocket costs you may pay for covered services

[Describe all applicable types of cost sharing our plan uses. You can omit those that aren't applicable. Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing should explain the differences in cost-sharing responsibility, clearly indicating that for those members who get Medicare cost-sharing help under Medicaid pay nothing, or the Medicaid copay, if applicable, for their covered services as long as they follow our plan's rules for getting their care because they get help from Medicaid with Medicare Part A and B cost sharing.]

[Plans with no cost sharing, revise section heading to "You pay nothing for your covered services" and replace section with the following: Because you get help from Medicaid, you pay nothing for your covered services as long as you follow our plans' rules for getting your care. (Go to Chapter 3 for more information about our plans' rules for getting your care.)]

Types of out-of-pocket costs you may pay for covered services include:

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

- **Deductible:** 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 our plan deductible.)] [Insert if applicable: (Section 1.3 tells you more about your deductibles for certain categories of services.)]*
- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** 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 tells you more about your coinsurance.)

Section 1.2 Our plan deductible

[Plans with no deductibles, delete this section and renumber remaining subsections in Section 1.] [POS plans with a deductible that applies only to POS services: modify this section as needed.]

Your deductible is *[insert deductible amount]*. Until you've paid the deductible amount, you must pay the full cost of your covered services. After you pay your deductible, we'll start to pay our share of the costs for covered medical services, and you'll 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 can revise the paragraph to describe the services that are subject to the deductible.] The deductible doesn't apply to some services. This means that we pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible doesn't apply to the following services:

- *[Insert services not subject to the deductible. Plans must include the \$0.00 Medicare preventive services, emergency/urgently needed services and insulin furnished through an item of durable medical equipment.]*

[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: If you're eligible for Medicare cost-sharing help under Medicaid, you have no deductible.]

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

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 from network providers

[Plans with service category deductibles: insert this section. If applicable, plans can 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 our plan deductible that applies to all covered medical services, we also have a deductible for certain types of services.]

[Insert if plan doesn't 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: Our plan has a deductible amount for certain services. Until you've paid the deductible amount, you must pay the full cost for *[insert service category]*. After you pay your deductible, we'll pay our share of the costs for these services, and you'll pay your share. *[Insert if applicable: Both our plan deductible and the deductible for *[insert service category]* apply to your covered *[insert service category]*. This means that once you meet either our plan deductible or the deductible for *[insert service category]*, we'll start to pay our share of the costs of your covered *[insert service category]*.]** The Medical Benefits Chart shows the service category deductibles.

[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: If you're eligible for Medicare cost-sharing help under Medicaid, you have no deductible.]

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

[POS plans can revise this information as needed to describe our plan's MOOP(s).]

Note: Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. *[Plans that only include members who don't pay Parts A and B service cost sharing insert: You're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.]* *[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: If you're eligible for Medicare cost-sharing help under*

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Medicaid, you're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.]

Medicare Advantage Plans have limits on the amount you have to pay out-of-pocket each year for medical services covered *[insert as applicable: under Medicare Part A and Part B OR by our plan]*. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2027 the MOOP amount 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 can modify the following sentence as needed.]* The amounts you pay for plan premiums and Part D drugs don't 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 don't 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 won't 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: our 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 if applicable: Part A and Part B]* services (described above), we also have a separate maximum out-of-pocket amount that applies only to certain types of services.

Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. *[Plans that only include members who don't pay Parts A and B service cost sharing insert: You're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.]* *[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: If you're eligible for Medicare cost-sharing help under Medicaid you're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.]]*

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

*[Insert if plan has one service category MOOP: Our plan has a maximum out-of-pocket amount of *[insert service category MOOP]* for *[insert service category]*. Once you've paid *[insert service category MOOP]* out-of-pocket for *[insert service category]*, our 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've 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]*, our plan will cover your *[insert service category]* at no cost to you for the rest of the year.]* The Medical Benefits Chart shows the service category out-of-pocket maximums.]*

Section 1.6 Providers aren't allowed to balance bill you

[Plans that are zero cost-share plans or approved to exclusively enroll full-benefit dual eligible people who don't pay Parts A and B service cost sharing delete section.]

As a member of *[insert 2027 plan name]*, you have an important protection because *[plans with a plan-level deductible insert: after you meet any deductibles,]* you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
 - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

- If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).

[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: We don't allow providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service. If you get a bill from a provider, call Member Services at [insert Member Services number] (TTY users call [insert TTY number]).]

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services *[insert 2027 plan name]* covers *[plans with cost sharing insert: and what you pay out of pocket for each service]* (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare *[insert if plan is describing Medicaid services in chart: and Medicaid]* covered services must be provided according to Medicare *[insert if plan is describing Medicaid services in chart: and Medicaid]* coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- *[Insert if applicable: You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered unless it's emergency or urgent care, or unless our plan or a network provider gave you a referral. This means that you pay the provider in full for out-of-network services you get.]*
- *[Insert if applicable: You have a primary care provider (a PCP) providing and*

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

overseeing your care. *[Plans that don't require referrals can omit the rest of this bullet]*
In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.]

- *[Insert if applicable: Some services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart [Insert as appropriate: by an asterisk OR by a footnote OR in bold OR in italics] [Insert if applicable: These services not listed in the Medical Benefits Chart also require prior authorization: [insert list].]*
- *[Insert as applicable: If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.]*
- *[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 [insert Member Services number] (TTY users call [insert TTY number]) if you have questions about these administrative fees.]*

Other important things to know about our coverage:

- You're covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services, including *[Plans can add references to the specific types of cost sharing Medicaid pays for]*. Medicaid also covers services Medicare doesn't cover, like *[Plans can add references to long-term care, over-the-counter drugs, home and community-based services, or other Medicaid-only services]*.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You* 2027 handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. *[Insert as applicable: However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.]*
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

- *[FIDE SNPs and HIDE SNPs should provide a description of how they integrate Medicare and Medicaid benefits for the member and how the Medical Benefits Chart reflects those integrated benefits as well as impacts on cost sharing.]*
- If you're within our plan's *[Insert number 1-6. Plans can choose any length of time from one to 6 months for deeming continued eligibility, as long as they apply the criteria consistently across all members and fully inform members of the policy]*-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, *[Plans should specify policy regarding coverage of Medicaid benefits during the period of deemed continued eligibility, as defined in the State Medicaid Agency Contract. For example, "we won't continue to cover Medicaid benefits that are included under the applicable Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. The amount you pay for Medicare-covered services may increase during this period."]*

[Plans that don't have cost sharing should insert: You don't pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.]

*[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: **If you're eligible for Medicare cost-sharing help under Medicaid, you don't pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.**]*

[Instructions to plans offering Value-Based Insurance Design (VBID) Model benefits for enrollees with certain chronic conditions:]

- *Plans can deliver to each clinically targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they're eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering a written notice when offering targeted supplemental or VBID benefits. (See CY 2027 Value-Based Insurance Design Communications and Marketing Guidelines).*
- *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 VBID benefits.*
- *If applicable, plans with VBID should mention reduced cost sharing for their MA benefits, as well as that members may qualify for a reduction or elimination of their cost sharing*

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

for Part D drugs in plans with VBID may include the reduction or elimination of their cost sharing for Part D drugs in Chapter 6, Section 2.]

- *[Insert if offering VBID Model benefits:]*

Important Benefit Information for People with Certain Chronic Conditions

- *If you're diagnosed by a plan provider with any of the chronic condition(s) listed below and meet certain medical criteria, you may be eligible for targeted supplemental benefits and/or reduced cost sharing:*

- *[List all applicable chronic conditions here.]*

- *[As applicable, plans offering benefits under VBID that require participation in a health and wellness program or to see a high value provider, include those limitations and then direct the enrollee that they will be provided additional information with how to take advantage of these additional supplemental benefits. (See CY 2025 Value Based Insurance Design Communications and Marketing Guidelines).]*

- *For more detail, go to the **VBID** row in the below Medical Benefits Chart below.]*

[Instructions to plans offering Value-Based Insurance Design (VBID) Model benefits for enrollees living in certain geographic areas:]

- *Plans can deliver to each geographically targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they're eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering such a written notice when offering targeted supplemental or VBID benefits. (See CY 2025 Value Based Insurance Design Communications and Marketing Guidelines).*
- *Plans that choose to reduce cost sharing for an item or service, must include a summary of the additional supplemental benefits the enrollee would get as well as the activities and/or programs the member must complete to get the benefit.*
- *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 VBID.]*
- *[Insert if offering VBID Model benefits:]*
- Important Benefit Information for People Living in Certain Geographic Areas

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

- ~~If you live in certain geographic areas listed below, you may be eligible for targeted supplemental benefits and/or reduced cost sharing:~~
- ~~[List all applicable census tracts and blocks groups here (e.g., Census Tract 9800—Block Group 1); organize by county for readability].~~
 - ~~[Insert a phone number for enrollees to call for help with identifying eligibility and determining the enrollee's Census Tract and Block Group, include the plan web address for more information on supplemental benefits and/or reduced cost sharing for enrollees living in certain geographic areas.]~~
 - ~~[As applicable, plans can enter an explanation of how enrollees can identify the census tract and block group they live in. For example, plans can provide the link and instructions/video on how to locate your own census tract and block by entering their address in <https://geocoding.geo.census.gov/geocoder/geographies/address?form.>]~~
 - ~~[As applicable, plans offering benefits under VBID that require participation in a health and wellness program or to see a high-value provider, include those limitations and instruct the enrollee they will be provided additional information on how to take advantage of these additional supplemental benefits. (See CY 2025 Value-Based Insurance Design Communications and Marketing Guidelines).]~~
 - ~~For more detail, go to the **VBID** row in the Medical Benefits Chart below.]~~

[Important Benefit Information for People Who Qualify for Extra Help:

- ~~If you get Extra Help to pay your Medicare drug coverage costs, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.~~
- ~~For more detail, go to the **VBID** row in the Medical Benefits Chart below.]~~

[Instructions to plans offering VBID benefits for LIS Targeted Enrollees:

- ~~Plans can deliver to each LIS-targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they're eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering such a written notice when offering targeted supplemental or VBID benefits. (See CY 2025 Value-Based Insurance Design Communications and Marketing Guidelines).~~
- ~~Plans who choose to reduce cost sharing for an item or service, including Part D drugs covered by MA-PD plan through member participation in a plan-sponsored disease management or similar program, must include a summary of the additional~~

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

~~*supplemental benefits they would get as well as the activities and/or programs the member must complete in order to get the benefit.*~~

- ~~*• 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 VBID benefits.*~~
- ~~*• If applicable, plans with VBID should mention that members may qualify for a reduction or elimination of their cost sharing for Part D drugs in Chapter 6, Section 2.*~~

[Instructions to plans offering MA Uniformity Flexibility benefits:

- Plans must deliver to each clinically targeted enrollee a written summary of those benefits or information in alignment with its different strategy for communicating information regarding MA Uniformity Flexibility Benefits so that such enrollees are notified of the MA Uniformity Flexibility benefits for which they're 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.]*

[Important Benefit Information for People Who Qualify for Extra Help:

- If you get Extra Help to pay your Medicare drug coverage costs, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.*

[Insert if offering Special Supplemental Benefits for the Chronically Ill: Important Benefit Information for Enrollees with Chronic Conditions

- If you're diagnosed with any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.

 - [List all applicable chronic conditions here.]*
 - [Include information regarding the process and/or criteria for determining eligibility for special supplemental benefits for the chronically ill]**
- For more detail, go to the Special Supplemental Benefits for the Chronically Ill row in the Medical Benefits Chart below.*
- Contact us to find out exactly which benefits you may be eligible for.]*



This apple shows the preventive services in the Medical Benefits Chart.

[Instructions on completing the Medical Benefits Chart:

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

- *Plans may format the chart to accommodate page breaks and determine the appropriate location of the "Benefit" title if an existing benefit continues to the next page.*
- *If using Medicare FFS amounts (e.g., Inpatient and SNF cost sharing) our plan must insert the 2026 Medicare amounts and must insert: These are 2026 cost-sharing amounts and may change for 2027. [Insert plan name] will provide updated rates as soon as they're released. Member cost-sharing amounts can't be left blank.*
- *For all preventive care and screening test benefit information, plans that cover a richer benefit than Original Medicare don't need to include given description (unless still applicable) and can instead describe plan benefit.*
- *Optional supplemental benefits aren't permitted within the chart; optional supplemental benefits can be described within Section 2.2.*
- *Plans with out-of-network services must clearly indicate for each service, both the in-network and out-of-network cost sharing.*
- *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 special characters and/or footnotes indicating such in the Provider Directory (When one reads the Provider Directory, it is clear what the special character and/or footnote means when reading this section of the EOC. Refer to the current Medicare Advantage and Section 1876 Cost Plan Provider Directory Model for more information.).*
- *Plans with a POS benefit can include POS information within the Medical Benefits Chart or can include a section following the chart listing POS-eligible benefits and cost sharing.*
- *Plans should clearly indicate which benefits are subject to PA (plans can use asterisks or similar method).*
- *Plans can insert any additional benefits information based on our plan's approved bid that isn't captured in the Medical Benefits Chart or in the exclusions section. FIDE SNPs and HIDE SNPs can add Medicaid-only benefits they cover to the Medical Benefits Chart. 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 can add references to the list of exclusions in Section 3 as appropriate.*
- *Plans can modify the language, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population. SNPs must, at a minimum, include the Medicaid benefits provided by our plan and must distinguish Medicaid coverage from Medicare coverage for benefits covered by both programs or by Medicaid only. FIDE SNPs and HIDE SNPs can add Medicaid-only benefits to the Medical Benefits Chart along with the*


Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Medicare benefits (rather than in a separate section). We encourage plans choosing this option to work with the state Medicaid agencies with which they contract to develop integrated benefits language as appropriate. Alternatively, plans can add a new section to the chart to describe Medicaid benefits. Plans that don't include a complete list of Medicaid benefits within the chart should refer readers to the Summary of Medicaid-Covered Benefits in the Summary of Benefits. Plans must include a complete list of Medicaid benefits if the Summary of Benefits doesn't include the required comprehensive written statement. Plans can also state that members should contact their Medicaid Agency to determine their level of cost sharing.


- *Plans must make it clear for members (in the sections where member cost sharing is shown) whether its hospital copayments or coinsurance apply on the date of admission and / or on the date of discharge.]*
- *[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing should clearly note the different cost-sharing amounts applicable to each group of members in the Medical Benefits Chart, either within the "What you must pay when you get these services chart" or by adding a column to differentiate the cost-sharing amounts for each group of members.]*

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)




Medical Benefits Chart

Covered Service	What you pay
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our 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. <i>[Also list any additional benefits offered.]</i>	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 under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: <ul style="list-style-type: none"> • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for 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. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:	<i>[List copayment / coinsurance / deductible.]</i>




Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<ul style="list-style-type: none"> a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p> <p><i>[Also list any additional benefits offered.]</i></p>	
<p>Ambulance services</p> <p>Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be 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.</p>	<p><i>[List copayment/coinsurance/deductible. Specify whether cost sharing applies one-way or for round trips.]</i></p>
<p> Annual wellness visit</p> <p>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.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i> visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
 Bone mass measurement For qualified people (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. <i>[Also list any additional benefits offered.]</i>	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
 Breast cancer screening (mammograms) Covered services include: <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months <i>[Also list any additional benefits offered.]</i>	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 <i>[insert as appropriate: referral OR order]</i> . Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. <i>[Also list any additional benefits offered.]</i>	<i>[List copayment/coinsurance/deductible]</i>
 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. <i>[Also list any additional benefits offered.]</i>	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.



Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
 Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). <i>[Also list any additional benefits offered.]</i>	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
 Cervical and vaginal cancer screening Covered services include: <ul style="list-style-type: none"> For all women: Pap tests and pelvic exams are covered once every 24 months If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months <i>[Also list any additional benefits offered.]</i>	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: <ul style="list-style-type: none"> <i>[If our plan only covers manual manipulation, insert: We cover only]</i> Manual manipulation of the spine to correct subluxation <i>[Also list any additional benefits offered.]</i>	<i>[List copayment / coinsurance / deductible]</i>
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. <i>[List copayment / coinsurance / deductible]</i>
 Colorectal cancer screening The following screening tests are covered: <ul style="list-style-type: none"> Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous 	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes


Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy.</p> <ul style="list-style-type: none"> • Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, 	<p>a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam <i>[and subject to copayment/coinsurance].</i> <i>[Our plan should list applicable copayment and coinsurance.]</i> <i>[If applicable, list copayment and/or coinsurance charged for barium enema.]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>as a result of, and in the same clinical encounter as the screening test.</p> <p><i>[Also list any additional benefits offered.]</i></p>	
<p><i>[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.]</i></p> <p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover:</p> <p><i>[List any additional benefits offered, such as diagnostic, preventive, and comprehensive dental care.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
<p> Depression screening</p> <p>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.</p> <p><i>[Also list any additional benefits offered.]</i></p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of these 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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</p>


Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p> <p><i>[Also list any additional benefits offered.]</i></p>	
<p> Diabetes self-management training, diabetic services, and supplies</p> <p><i>[Plans can put items listed under a single bullet or in separate bullets if our plan charges different copayments. However, all items in the bullets must be included.]</i> For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> 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 2 additional pairs of inserts, or one pair of depth shoes and 3 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. <p><i>[Also list any additional benefits offered.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
<p>Durable medical equipment (DME) and related supplies</p> <p>(For a definition of durable medical equipment, go to Chapter 12 and Chapter 3)</p> <p>Covered items include, but aren't 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.</p>	<p><i>[List copayment/coinsurance/deductible]</i></p> <p>Your cost sharing for Medicare oxygen equipment coverage is <i>[Insert copay amount or coinsurance percentage], every [Insert required frequency of payment].</i></p>


Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p><i>[Plans that don't 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 doesn't carry a particular brand or manufacturer, you can 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 document.] The most recent list of suppliers is [insert as applicable: also] available on our website at [insert URL].]</i></p> <p><i>[Plans that limit the DME brands and manufacturers that you will cover insert: With this Evidence of Coverage document, we sent you [insert 2027 plan name]'s list of DME. The list shows the brands and manufacturers of DME we cover. [Insert as applicable: We included a copy of our DME supplier directory in the envelope with this document]. This most recent list of brands, manufacturers, and suppliers is also available on our website at [insert URL].]</i></p> <p>Generally, <i>[insert 2027 plan name]</i> covers any DME covered by Original Medicare from the brands and manufacturers on this list. We won't cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. If you're new to <i>[insert 2027 plan name]</i> and using a brand of DME not on our list, we'll 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 after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)</p> <p>If you (or your provider) don't agree with our plan's coverage decision, you or your provider can 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, go to Chapter 9)]</p>	<p><i>[Plans that use a constant cost-sharing structure for oxygen equipment insert: Your cost sharing won't change after you're enrolled for 36 months.]</i></p> <p><i>[Plans that want to vary cost sharing for oxygen equipment after 36 months insert details including whether original cost sharing resumes after 5 years and you're still in our plan.] [If cost sharing is different for members who made 36 months of rental payments prior to joining our plan insert:</i></p> <p>If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in <i>[insert 2027 plan name]</i>, your cost sharing in <i>[insert 2027 plan name]</i> is <i>[insert cost sharing].]</i></p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p>	<p><i>[List copayment / coinsurance. If applicable,</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<ul style="list-style-type: none"> Furnished by a provider qualified to furnish emergency services, and Needed to evaluate or stabilize an emergency medical condition. <p>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 (and, if you're a pregnant woman, loss of an unborn child), 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's quickly getting worse.</p> <p>Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.</p> <p><i>[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.]</i></p>	<p><i>explain that cost sharing is waived if member is admitted to hospital.]</i></p> <p><i>[Insert if applicable: If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, [Insert one or both: you must move to a network hospital for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the [insert if applicable: highest] cost sharing you would pay at a network hospital.]</i></p>
 Health and wellness education programs <p><i>[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.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
Hearing services <p>Diagnostic hearing and balance evaluations performed by your <i>[insert as applicable: PCP OR provider]</i> to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.</p>	<p><i>[List copayment / coinsurance / deductible]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<i>[List any additional benefits offered, such as routine hearing exams, hearing aids, and evaluations for fitting hearing aids.]</i>	
<p>Help with Certain Chronic Conditions</p> <p><i>[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.</i></p> <p><i>[If this benefit is not applicable, plans should delete this entire row.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> One screening exam every 12 months. <p>If you are pregnant, we cover:</p> <ul style="list-style-type: none"> Up to 3 screening exams during a pregnancy. <p><i>[Also list any additional benefits offered.]</i></p>	<p>There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care</p> <p><i>[If needed, plans can revise language about the doctor certification requirement.]</i> Before you get 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.</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> 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) 	<p><i>[List copayment / coinsurance / deductible]</i></p>


Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<ul style="list-style-type: none"> Physical therapy, occupational therapy, and speech therapy Medical and social services Medical equipment and supplies 	
<p>Home infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> Professional services, including nursing services, furnished in accordance with our plan of care Patient training and education not otherwise covered under the durable medical equipment benefit Remote monitoring Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier <p><i>[Also list any additional benefits offered.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>Hospice care</p> <p>You're 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. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.</p> <p>For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.</p> <p>For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization).</p> <ul style="list-style-type: none"> • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services 	<p>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 <i>[insert 2027 plan name]</i>.</p> <p><i>[Include information about cost sharing for hospice consultation services if applicable.]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<ul style="list-style-type: none"> If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare <p>For services covered by <i>[insert 2027 plan name]</i> but not covered by Medicare Part A or B: <i>[insert 2027 plan name]</i> will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services.</p> <p>For drugs that may be covered by our plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4).</p> <p>Note: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.</p> <p><i>[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.]</i></p>	
 Immunizations Covered Medicare Part B services include: <ul style="list-style-type: none"> Pneumonia vaccines 	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<ul style="list-style-type: none"> • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules <p>We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information. <i>[Also list any additional benefits offered.]</i></p>	
<p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.</p> <p><i>[List days covered and any restrictions that apply.]</i> Covered services include but aren't limited to:</p> <ul style="list-style-type: none"> • 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 	<p><i>[List all cost sharing (deductible, copayments/ coinsurance / deductible) 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.</i></p> <p><i>[In addition, if applicable, explain all other cost sharing that is charged during a benefit period.]</i></p>
<p>Inpatient hospital care (continued)</p> <ul style="list-style-type: none"> • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney- 	<p><i>[If cost sharing is not based on the Original Medicare or plan-defined</i></p>


Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant <i>[Plans with a provider network 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 2027 plan name] provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion.] [Plans can further define the specifics of transplant travel coverage.]</i></p> <ul style="list-style-type: none"> • Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood 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 starting with the first pint. <i>[Modify as necessary if our plan begins coverage with an earlier pint.]</i> • Physician services <p>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're not sure if you're an inpatient or an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>	<p><i>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.]</i></p> <p><i>[If inpatient cost sharing varies based on hospital tier, enter that cost sharing in the data entry fields.]</i></p> <p>If you get <i>[insert if applicable: authorized]</i> inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the <i>[Insert if applicable: highest]</i> cost sharing you'd pay at a network hospital.</p>


Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay. <i>[List days covered, restrictions such as 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital.]</i></p>	<p><i>[List all cost sharing (deductible, copayments/ coinsurance / deductible) 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.]]</i></p> <p><i>[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.]</i></p>
<p>Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay</p> <p><i>[Plans with no day limitations on a plan's hospital or SNF coverage can modify or delete this row as appropriate.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • 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 	
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when <i>[insert as appropriate: referred OR ordered]</i> by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's <i>[insert as appropriate: referral OR order]</i>. A physician must prescribe these services and renew their <i>[insert</i></p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>


Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p><i>as appropriate: referral OR order]</i> yearly if your treatment is needed into the next calendar year.</p> <p><i>[Also list any additional benefits offered.]</i></p>	
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services are covered for eligible people under all Medicare health plans.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>
<p>Medicare Part B drugs</p> <p><i>[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 422.111(d)]</i></p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could 	<p><i>[List copayment / coinsurance / deductible]</i></p> <p><i>[Indicate whether drugs may be subject to step therapy]</i> <i>[Indicate insulin cost sharing is subject to a coinsurance cap of \$35 for one-month's supply of insulin and specify service category or plan level deductibles don't apply.]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment.</p> <ul style="list-style-type: none"> • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® 	

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<ul style="list-style-type: none"> Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions. <i>[Plans can delete any of the following drugs that aren't covered under our plan.]</i> (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Parenteral and enteral nutrition (intravenous and tube feeding) <p><i>[Insert if applicable: This link will take you to a list of Part B drugs that may be subject to Step Therapy: insert link]</i></p> <p>We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit.</p> <p>Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.</p>	
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>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.</p> <p><i>[Also list any additional benefits offered.]</i></p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>
<p>Opioid treatment program services</p> <p>Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid</p>	<p><i>[List copayment / coinsurance / deductible]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments <p><i>[Plans can include other covered items and services as appropriate (not to include meals and transportation).]</i></p>	
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies <i>[List separately any services for which a separate copay/coinsurance applies over and above the outpatient radiation therapy copay/coinsurance.]</i> • 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 <i>[Modify as necessary if our plan begins coverage with an earlier pint.]</i> 	<p><i>[List copayment / coinsurance / deductible]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<ul style="list-style-type: none"> Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. Other outpatient diagnostic tests <i>[Plans can include other covered tests as appropriate.]</i> 	
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
<p>Outpatient hospital services</p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery Laboratory and diagnostic tests billed by the hospital 	<p><i>[List copayment / coinsurance / deductible]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<ul style="list-style-type: none"> • 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 you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff.</p> <p><i>[Also list any additional benefits offered.]</i></p>	
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p> <p><i>[Also list any additional benefits offered.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
<p>Outpatient rehabilitation services</p> <p>Covered services include physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
<p>Outpatient substance use disorder services</p> <p><i>[Describe our plan's benefits for outpatient substance abuse services.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're 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.</p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
<p>Partial hospitalization services and Intensive outpatient services</p> <p><i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.</p> <p><i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.</p> <p><i>[Plans that don't have an in-network community mental health center can add: Note: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical 	<p><i>[List copayment / coinsurance / deductible]</i></p> <p><i>[If applicable, indicate whether there are different cost-sharing amounts for Part B service(s) furnished]</i></p>



Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>center, hospital outpatient department, or any other location</p> <ul style="list-style-type: none"> • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your <i>[insert as applicable: PCP OR specialist]</i>, if your doctor orders it to see if you need medical treatment • <i>[Insert if providing any MA additional telehealth benefits consistent with 42 CFR § 422.135 in our plan's CMS-approved Plan Benefit Package submission: Certain telehealth services, including: [insert general description of covered MA additional telehealth benefits, i.e., the specific Part B service(s) our plan has identified as clinically appropriate to furnish through electronic exchange when the provider is not in the same location as the enrollee. Plans may want to refer enrollees to its medical coverage policy here.]</i> <ul style="list-style-type: none"> ○ 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. <i>[Modify as necessary if plan benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.]</i> ○ <i>[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.]</i> • <i>[Insert if our plan's service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act: Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare]</i> • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home 	<p><i>through an in-person visit and those furnished through electronic exchange as MA additional telehealth benefits.]</i></p>



Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<ul style="list-style-type: none"> • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while getting these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The evaluation isn't related to an office visit in the past 7 days and ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion <i>[Insert if appropriate: by another network provider]</i> prior to surgery <p><i>[Also list any additional benefits offered.]</i></p>	



Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
Podiatry services Covered services include: <ul style="list-style-type: none"> • 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 <i>[Also list any additional benefits offered.]</i>	<i>[List copayment / coinsurance / deductible]</i>
 Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we covers pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: <ul style="list-style-type: none"> • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	There is no coinsurance, copayment, or deductible for the PrEP benefit.
 Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test <i>[Also list any additional benefits offered.]</i>	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to	<i>[List copayment / coinsurance / deductible]</i>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to <i>Vision Care</i> later in this table for more detail.</p>	
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and <i>[insert as appropriate: a referral OR an order]</i> for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p> <p><i>[Also list any additional benefits offered.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 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.</p> <p><i>[Also list any additional benefits offered.]</i></p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified people, a LDCT is covered every 12 months.</p> <p>Eligible members are people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.</p>


Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must get an 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 later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	
<p> Screening for Hepatitis C Virus infection</p> <p>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:</p> <ul style="list-style-type: none"> You're at high risk because you use or have used illicit injection drugs. You had a blood transfusion before 1992. You were born between 1945-1965. <p>If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.</p>
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>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.</p> <p>We also cover up to 2 people 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>sexually active adults at increased risk for STIs. We 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.</p> <p><i>[Also list any additional benefits offered.]</i></p>	
<p>Services to treat kidney disease</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 6 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, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're 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) <p>Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to Medicare Part B drugs in this table.</p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.)</p> <p><i>[List days covered and any restrictions that apply, including whether any prior hospital stay is required.]</i> Covered services include but aren't limited to:</p>	<p><i>[List copayment / coinsurance / deductible. If cost sharing is based on benefit period, include definition / explanation of BID approved benefit period here.]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<ul style="list-style-type: none"> • 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 our 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 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. <i>[Modify as necessary if our plan begins coverage with an earlier pint.]</i> • 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 <p>Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital 	
 Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered</p>



Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:</p> <ul style="list-style-type: none"> • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling <p>We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)</p> <p><i>[Also list any additional benefits offered.]</i></p>	<p>smoking and tobacco use cessation preventive benefits.</p>
<p>Special Supplemental Benefits for the Chronically Ill</p> <p><i>[Enrollees with chronic condition(s) that meet certain criteria may be eligible for supplemental benefits for the chronically ill. The chronic conditions and benefits must be listed here. The benefits listed here must be approved in the bid. Describe the nature of the benefits and eligibility criteria here. If this benefit is not applicable, plans should delete this row.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) <i>[Optional: and a referral for PAD from the physician responsible for PAD treatment]</i>.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • 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 	<p><i>[List copayment / coinsurance / deductible]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<ul style="list-style-type: none"> 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 <p>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.</p> <p><i>[Also list any additional benefits offered.]</i></p>	
<p>Urgently needed services</p> <p>A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. <i>[Include in-network benefits. Also identify whether this coverage is within the U.S. or as a supplemental world-wide emergency/urgent coverage.]</i></p>	<p><i>[List copayment / coinsurance. Plans should include different copayments for contracted urgent care centers, if applicable.]</i></p>
<p>Value-Based Insurance Design (VBID) Model</p> <p><i>[Enrollees with chronic condition(s), enrollees who qualify for Extra Help, or enrollees in geographic areas that meet certain criteria may be eligible for VBID targeted supplemental benefits and/or reduced cost sharing. The eligibility criteria and benefits must be listed here. The benefits listed here must be approved in the bid. Describe the nature of the benefits and eligibility criteria here.]</i></p>	<p><i>[List copayment / coinsurance / deductible]</i></p>

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<i>If this benefit is not applicable, plans should delete this row.</i>	
 Vision care Covered services include: <ul style="list-style-type: none"> • 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 for glaucoma, we 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 • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. <i>[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 Medical Benefits Chart; they should be described within Section 2.2.]</i>	<i>[List copayment / coinsurance / deductible]</i>
 Welcome to Medicare preventive visit Our plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots), and referrals for other care if needed.	There is no coinsurance, copayment, or deductible for the <i>Welcome to Medicare</i> preventive visit.

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Covered Service	What you pay
<p>Important: We cover the <i>Welcome to Medicare</i> 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 want to schedule your <i>Welcome to Medicare</i> preventive visit.</p>	

Section 2.1 Extra optional supplemental benefits you can buy

[Include this section if you offer optional supplemental benefits in our plan and describe benefits below. Plans must explain how these benefits are different than what is covered under Medicaid and must indicate if any of the optional supplemental benefits are covered by Medicaid. You may include this section either in the EOC or as an insert to the EOC.]

Our plan offers some extra benefits that aren't covered by Original Medicare and not included in your benefits package. 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, copayments and coinsurance and rules using a chart like the Medical 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 Open Enrollment Period).]

Section 2.2 Get care using our plan's optional visitor/traveler benefit

[If our 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 traveler benefits and rules about getting the out-of-area coverage, including the impact based on Medicaid requirements if applicable. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR 422.74(b)(4)(iii) (for more than 6 months up to 12 months) also explain that here based on the language suggested below.]

If you don't permanently move, but you're continuously away from our plan's service area for more than 6 months, we usually must disenroll you from our plan. However, we offer a

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

visitor/traveler program *[specify areas where the visitor/traveler program is being offered]*, which will allow you to stay enrolled in our plan when you're outside of our service area for less than 12 months. Under our visitor/traveler program you can get all plan covered services at in-network cost sharing. Contact our plan for help in locating a provider when using the visitor/traveler benefit.

If you're in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you don't return to our plan's service area within 12 months, you'll be disenrolled from our plan.]

SECTION 3 Services covered outside of *[insert 2027 plan name]*

[Plans should use this section to include additional benefits covered outside our plan by Medicaid, as appropriate. Plans should modify as necessary to describe whether the benefits are available through Fee-for-Service Medicaid and/or a Medicaid managed care plan.]

The following services aren't covered by *[insert plan name]* but are available through Medicaid:

SECTION 4 Services that aren't covered by *[insert as applicable: our plan OR Medicare ([insert if applicable: Medicare] exclusions) OR Medicaid]*

This section tells you what services are excluded *[insert if applicable: by Medicare]*.

The chart below lists services and items that aren't covered by *[insert as applicable: our plan OR Medicare OR Medicaid]* under any conditions or are covered by *[insert as applicable: our plan OR Medicare OR Medicaid]* only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided: 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 Chapter 9, Section 6.3.)

[The services listed in the chart are excluded from Original Medicare's benefit package. If any services below are covered supplemental Medicare benefits, delete them from this list. If plans partially exclude services excluded by Medicare, they can revise the text accordingly to describe the extent of the exclusion. Plans may add parenthetical references to the Medical Benefits

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Chart for descriptions of covered services/items as appropriate. Plans may reorder the below excluded services alphabetically if they want. Plans may also add exclusions as needed.

When Medicare exclusions are covered by our plan under Medicaid, plans should keep the item/service but modify language as needed to indicate that the benefits are covered by our plan under Medicaid.]

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances
Cosmetic surgery or procedures	<p>Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member</p> <p>Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance</p>
Custodial care Custodial care is personal care that doesn't 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	Not covered under any condition
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	<p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan</p> <p>(Go to Chapter 3, Section 5 for more information on clinical research studies)</p>
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Not covered under any condition

Chapter 4 Medical Benefits Chart (what is covered *[plans with cost sharing insert: and what you pay]*)

Services not covered by Medicare	Covered only under specific conditions
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with, diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Routine dental care, such as cleanings, fillings, or dentures	Not covered under any condition
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Routine hearing exams, hearing aids, or exams to fit hearing aids	Not covered under any condition
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:

Using plan coverage for Part D drugs

How can you get information about your drug costs *[Plans that are approved to exclusively enroll QMBs, SLMBs, QIs, or dual eligible people with full Medicaid benefits, omit the rest of this question.]* **if you're getting Extra Help with your Part D drug costs?**

*[Plans that are approved to exclusively enroll QMBs, SLMBs, QIs, or dual eligible people with full Medicaid benefits insert this language: Because you're eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you're in the Extra Help program, **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.**]* *[Other plans insert: Most of our members qualify for and are getting Extra Help from Medicare to pay for their prescription drug plan costs. If you're in the Extra Help program, **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. *[Plans may indicate LIS Rider mail date.]* If you don't have this insert, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) and ask for the *LIS Rider*. (Phone numbers for Member Services are printed on the back cover of this document.)

SECTION 1 Basic rules for our plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. *[Insert as appropriate: Our Drug List tells you how to find out about your Medicaid drug coverage. OR [Insert language about where member can learn about Medicaid drug coverage].]*

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law.

- Your prescriber must not be on Medicare’s Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Go to Section 2) *[insert if applicable: or you can fill your prescription through our plan’s mail-order service].*)
- Your drug must be on our plan’s Drug List (Go to Section 3).
- Your drug must be used for a medically accepted indication. A “medically accepted indication” is a use of the drug that’s either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information)

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

In most cases, your prescriptions are covered *only* if they’re filled at our plan’s network pharmacies. (Go to Section 2.5 for information about when we cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered drugs. The term “covered drugs” means all the Part D drugs on our plan’s Drug List.

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website (*[insert direct URL to pharmacy directory]*), and/or call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).

You may go to any of our network pharmacies. *[Insert if plan has pharmacies that offer preferred cost sharing in its network: Some network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The Pharmacy Directory will tell you which network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.]*

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. *[Insert if applicable: If the pharmacy you use stays in our network but no longer offers preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available.]* To find another pharmacy in your area, get help from Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) or use the *Pharmacy Directory*. *[Insert if applicable: You can also find information on our website at *[insert website address]*.]*

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy. *[Plans can insert additional information about home infusion pharmacy services in our plan's network.]*
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting your Part D drugs in an LTC facility, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*). *[Plans can insert additional information about LTC pharmacy services in our 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 can insert additional information about I/T/U pharmacy services in our plan's network.]*
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Pharmacy Directory* *[insert direct URL to pharmacy directory]* or call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).

Section 2.2 Our plan's mail-order service

[Omit if our plan doesn't 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 our plan's network mail-order service. Generally, the drugs provided through mail order are drugs you take on a regular basis, for a chronic or long-term medical condition. *[Insert if plan marks mail-order drugs in formulary: These drugs are marked as **mail-order drugs** in our Drug List.]**

[Insert if plan marks non-mail-order drugs in formulary: The drugs that aren't available through our 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 can 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 be delivered to you in no more than [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 will automatically process new prescriptions consistent with the policy described in the December 12, 2013, HPMS memo and 2016 Final Call Letter; and ii) whether the sponsor offers an optional automatic refill program consistent with policy described in the 2020 Final Call Letter. 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 2 options.]

*[**Option 1:** Sponsors that **don't** automatically process new prescriptions from provider offices, insert the following:*

New prescriptions the pharmacy gets directly from your doctor's office.

After the pharmacy gets 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. It is important to respond each time you're contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.]

*[**Option 2:** Sponsors that **do** automatically process new prescriptions from provider offices, insert the following:*

New prescriptions the pharmacy gets directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it gets 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 can ask for automatic delivery of all new prescriptions at any time by *[insert instructions]*.

If you get a prescription automatically by mail that you don't 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 don't want the pharmacy to automatically fill and ship each new prescription, contact us by *[insert instructions]*.

If you 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. It's important to respond each time you're contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, contact us by *[insert instructions]*.

[For refill prescriptions, insert one of the following 2 options.]

[Option 1: Sponsors that **don't** offer a program that automatically processes refills, insert the following:

Refills on mail-order prescriptions. For refills, contact your pharmacy *[insert recommended number of days]* days before your current prescription 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 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 before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy *[insert recommended number of*

days] days before your current prescription will run out. This will ensure your 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, contact us by *[insert instructions].*

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

[Plans that don't offer extended-day supplies: Delete Section 2.3.]

[Insert if applicable: When you get a long-term supply of drugs, your cost sharing may be lower.] Our plan offers *[insert as appropriate: a way OR 2 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 you take on a regular basis, for a chronic or long-term medical condition.)

1. *[Insert if applicable: Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs [insert if applicable: (which offer preferred cost sharing)] at [insert as appropriate: a lower OR the mail-order] cost-sharing amount. [Insert if applicable: Other retail pharmacies may not agree to the [insert as appropriate: lower OR mail-order] cost-sharing amounts. In this case you're responsible for the difference in price.]* Your *Pharmacy Directory* *[insert direct URL to 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 at *[insert Member Services number]* (TTY users call *[insert TTY number]*) for more information
2. *[Delete if plan doesn't offer mail-order service.]* You can also get maintenance drugs through our mail-order program. Go to Section 2.3 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. *[Insert if applicable: We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan.]* **Check first with Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

[Plans should insert a list of situations when they will cover prescriptions out of the network and any limits on its out-of-network policies, including for self-administered drugs provided in an outpatient setting (e.g., day supply limits, use of mail order during extended out of area travel, authorization, or plan notification).]

[Plans with an arrangement with the state can add language to reflect that the organization isn't allowed to reimburse members for Medicaid-covered benefits.] If you must use an out-of-network pharmacy, you'll generally have to pay the full cost *[plans with cost sharing, insert: (rather than your normal cost share)]* at the time you fill your prescription. You can ask us to reimburse you *[plans with cost sharing, insert: for our share of the cost]*. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

SECTION 3 Your drugs need to be on our plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, **we call it the Drug List**.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug List only shows drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. *[Insert as appropriate: The Drug List tells you how to find out about your Medicaid drug coverage. OR [insert language about where member can learn about Medicaid drug coverage].]*

We generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and use of the drug for a medically accepted indication. A medically accepted indication is a use of the drug that's *either*:

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

[Plans that aren't offering indication-based formulary design should delete this section.]

Certain drugs may be covered for some medical conditions but considered non-formulary for other medical conditions. These drugs will be identified on our Drug List and on www.Medicare.gov, along with the specific medical conditions that they cover.

Chapter 5 Using plan coverage for Part D drugs

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

[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 at *[insert Member Services number]* (TTY users call *[insert TTY number]*).] *[Plans that offer both a Part C and Part D over-the-counter benefit should explain i) what can be purchased by each program, ii) what can be purchased by both programs, iii) the effects of using one program or the other.]*

Drugs that aren't on the Drug List

[If our plan doesn't include Medicaid-covered drugs on the Drug List, add information indicating that these drugs aren't included and where the member can find this information.]

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that isn't on our Drug List. (For more information, go to Chapter 9.)

Section 3.2 *[Insert number of tiers]* **cost-sharing tiers for drugs on the Drug List**

[Plans that don't use drug tiers should omit this section.]

Every drug on our plan's Drug List is in one of *[insert number of tiers]* cost-sharing tiers. In general, the higher the 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 our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 **How to find out if a specific drug is on the Drug List**

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we *[[insert: sent you in the mail] OR [insert: provided electronically]]*. *[Insert if applicable: (The Drug List includes information for the covered drugs most commonly used by our members. We cover additional drugs that aren't included in the Drug List. If one of your drugs isn't listed, visit our website or call Member Services at [insert Member Services number] (TTY users call [insert TTY number]) to find out if we cover it.)]*
- Visit our plan's website (*[insert URL]*). The Drug List on the website is always the most current.
- Call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (*[insert URL]*) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*). *[Plans can insert additional information about the "Real-Time Benefit Tool" such as rewards and incentives which can be offered to enrollees who use the "Real-Time Benefit Tool."]*
- *[Plans can insert additional ways to find out if a drug is on the Drug List.]*

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you 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. (Go to Chapter 9.)

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

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) or on our website *[insert direct URL to PA criteria]*.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical

condition and Drug A is less costly, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)) or on our website [\[insert direct URL to ST criteria\]](#).

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it's 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 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- [\[Omit if plan's formulary structure \(e.g., no tiers\) doesn't allow for tiering exceptions.\]](#) The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

[\[Omit if plan's formulary structure \(e.g., no tiers\) doesn't 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 5.1 to learn what you can do.**

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on our plan's Drug List OR is now restricted in some way.**

- **If you're a new member**, we'll cover a temporary supply of your drug during the first *[insert time period (must be at least 90 days)]* of your membership in our plan.
- **If you were in our plan last year**, we'll cover a temporary supply of your drug during the first *[insert time period (must be at least 90 days)]* of the calendar year.
- This temporary supply will be for a maximum of *[insert supply limit (must be at least the number of days in our plan's one-month supply)]*. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of *[insert supply limit (must be at least the number of days in our plan's one-month supply)]* of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than *[insert time period (must be at least 90 days)]* and live in a long-term care facility and need a supply right away:** We'll cover one *[insert supply limit (must be at least a 31-day supply)]* emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- *[If applicable: Plans must insert its transition policy for current members with level of care changes.]*

For questions about a temporary supply, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) 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.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can

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

[Plans can omit the following paragraph if they don't have an advance transition process for current members.] If you're a current member and a drug you take will be removed from the formulary or restricted in some way for next year, we'll tell you about any change before the new year. You can ask for an exception before next year and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement). If we approve your request, we'll authorize coverage for the drug before the change takes effect.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to 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 doesn't allow for tiering exceptions: omit Section 5.1.]

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, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) 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.

You can ask for an exception

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

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

*[Insert if our plan designated one of its tiers as a specialty tier for unique/high-cost drugs and is exempting that tier from the exceptions process: Drugs in our *[insert tier number and name of the tier designated as the specialty tier]* aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.]*

[Insert if our plan designated 2 of its tiers as specialty tiers, such that one of the specialty tiers is a preferred specialty tier with lower cost sharing relative to the other specialty tier and is exempting both of those tiers from the exceptions process to lower (non-specialty) tiers: Drugs in our [insert tier number and name of tier designated as the higher cost sharing specialty tier] are eligible for this type of exception to our [insert tier number and name of the tier designated as the preferred specialty tier]. However, drugs in our [insert tier numbers and names of 2 tiers designated as specialty tiers] aren't eligible for this type of exception to [insert tier numbers and names of the non-specialty tiers below the tiers designated as specialty tiers].]

SECTION 6 Our Drug List can change during the year

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

- **Add or remove drugs from the Drug List.**
- *[Plans that don't use tiers can omit]* **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- *[Insert as applicable: Replace an original biological product with an interchangeable biosimilar version of the biological product.]*

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes were made for a drug that you take.

Changes to drug coverage that affect you during this plan year

[Advance General Notice that plan sponsor may make certain immediate generic and biosimilar substitutions: To immediately replace brand name drugs or biological products with, respectively, new therapeutically equivalent or authorized generic drugs or interchangeable biological products or unbranded biological products (or to change the tiering or the restrictions, or both, applied if the related drug stays on the formulary), plan sponsors that otherwise meet the requirements must include this language:

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**

- We may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and *[Plans that don't use tiers can omit "on the same or lower cost-sharing tier and."]* with the same or fewer restrictions.
- We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
- We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.]

[All plan sponsors should include the remainder of this section.]

- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List** *[Plans that inserted the section on Advance General Notice for immediate substitutions insert:]*.

- When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and *[Plans that don't use tiers can omit "on the same or lower cost-sharing tier and"]* with the same or fewer restrictions.
- We'll make these changes only if we add a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
- We'll tell you at least 30 days before we make the change or tell you about the change and cover an *[insert supply limit (must be at least the number of days in our plan's one-month supply)]*-day fill of the version of the drug you're taking.

- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**

- Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you're taking that drug, we'll tell you after we make the change.

- **Making 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 example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
- We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional *[insert supply limit (must be at least the number of days in our plan's one-month supply)]*-day fill of the drug you take.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or ask for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug List that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- *[Plans that don't use tiers can omit]* We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

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

Some kinds of prescription drugs are *excluded*. This means *[insert as appropriate: Medicare doesn't pay OR neither Medicare nor Medicaid pays]* for these drugs.

If you appeal and the drug asked for is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.) *[Insert if applicable: If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself OR If the drug is excluded, you must pay for it yourself] [insert if applicable: (, except for certain excluded drugs covered under our enhanced drug coverage)]*.

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs listed below aren't covered by Medicare *[insert if list integrates Medicare and Medicaid exclusions: or Medicaid]*. *[Insert if list isn't integrated: However, some of these drugs may be covered for you under your Medicaid drug coverage [insert if plan notes categories with Medicaid coverage below: as indicated below.]] [If plan doesn't note categories with Medicaid coverage, insert an explanation of where members can find this information.]*

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

*[Insert if plan offers coverage for any drugs excluded under Part D: If you get **Extra Help from Medicare** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. (Go to our plan's Drug List or call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) for more information.) If you have drug coverage through Medicaid, your state Medicaid program may cover some drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)]*

*[Insert if plan doesn't offer coverage for any drugs excluded under Part D: **If you get Extra Help** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)]*

SECTION 8 How to fill a prescription

[Plans with members that need to show their Medicaid card to fill prescriptions for drugs covered under Medicaid should edit this section as needed.]

To fill your prescription, provide our plan membership information (which can be found on your membership card at the network pharmacy you choose. The network pharmacy will automatically bill our plan for *[plans with cost sharing insert: our share of the costs of]* your drug. *[Plans with no cost sharing, delete the next sentence.]* You'll need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

[Plans with an arrangement with the state can add language to reflect that the organization isn't allowed to reimburse members for Medicaid-covered benefits.] If the pharmacy can't 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** *[insert if plan has cost sharing: for our share]*. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this chapter.

Section 9.2 As 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 uses a pharmacy that supplies drugs for all its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* [\[insert direct URL to pharmacy directory\]](#) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that isn't on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also get drug coverage from an employer or retiree group plan

[\[Plans that cannot enroll members with employer or retiree coverage should delete this section.\]](#)

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

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage pays first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells you if your drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that our plan has drug coverage that's expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get 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 getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

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 like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same 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 for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

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

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers 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'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) *[insert if plan has other medication management programs: and other]* program *[insert if applicable: s]* to help members manage 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. Our *[if applicable replace: Our with One]* program is called a Medication Therapy Management (MTM) program. This program is *[if applicable replace with: These programs are]* voluntary and free. A team of pharmacists and doctors developed the program *[insert if applicable: s]* for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about 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 which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and 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'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program *[if applicable replace with: these programs]*, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).

CHAPTER 6:

What you pay for Part D drugs

[Plans with no cost sharing for Part D drugs, should move the information in Section 3 to Chapter 5, delete the rest of Chapter 6, and add: You pay nothing for Part D drugs covered by our plan.]

SECTION 1 What you pay for Part D drugs

We use “drug” in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B *[insert if applicable: or under Medicaid]*. *[Optional for plans that provide supplemental coverage: In addition, some excluded drugs may be covered by our plan if you purchased supplemental drug coverage.]*

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan’s “Real-Time Benefit Tool” to look up drug coverage (*[insert URL]*), the cost you see shows an estimate of the out-of-pocket costs you’re expected to pay. You can also get information provided in the “Real-Time Benefit Tool” by calling Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).

How can you get information about your drug costs *[Plans that are approved to exclusively enroll QMBs, SLMBs, QIs, or dual eligible people with full Medicaid benefits, omit the rest of this question.]* if you’re getting Extra Help with your Part D prescription drug costs?

*[Plans that are approved to exclusively enroll QMBs, SLMBs, QIs, or dual eligible people with full Medicaid benefits insert this language: Because you’re eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you have Extra Help, **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.**]*
*[Other plans insert: Most of our members qualify for and are getting Extra Help from Medicare to pay for their prescription drug plan costs. If you get Extra Help, **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

Chapter 6 What you pay for Part D drugs

[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. *[Plans may indicate LIS Rider mail date.]* If you don't have this insert, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) and ask for the *LIS Rider*.

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

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

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

Your out-of-pocket costs **include** the payments listed below (as long as they're for covered Part D drugs and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in 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 drug plan before you joined our plan
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, *[Plans without an SPAP in its state delete next item.]* State Pharmaceutical Assistance Programs (SPAPs), and most charities

Chapter 6 What you pay for Part D drugs

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$*[insert 2027 out-of-pocket threshold]* in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- *[Plans with no premium, omit]* Your monthly plan premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- *[Insert if plan doesn't 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 2 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 Drug Plan]*
- *[Insert if applicable: Payments you make toward drugs not normally covered in a Medicare Drug Plan]*
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).

Chapter 6 What you pay for Part D drugs

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches \$*[insert 2027 out-of-pocket threshold]*, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for *[insert 2027 plan name]* members

[Plans with a single payment stage: delete this section.]

There are **3 drug payment stages** for your drug coverage under *[insert 2027 plan name]*. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your *Part D Explanation of Benefits* explains which payment stage you're in

[Plans with no cost sharing: modify Section 3 and 3.1 as necessary and move it to Chapter 5.]

[Plans with a single payment stage: modify this section as necessary.]

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

Chapter 6 What you pay for Part D drugs

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable

Section 3.1 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 every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- [\[Plans with an arrangement with the state can add language to reflect that the organization isn't allowed to reimburse members for Medicaid-covered benefits.\]](#) **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't 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, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
 - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
 - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
 - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
 - If you're 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.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by [\[Plans without an SPAP in its state delete next item.\]](#) a

Chapter 6 What you pay for Part D drugs

State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. 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 get the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or have questions, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*). *[Plans that allow members to manage this information on-line can describe that option here.]* Be sure to keep these reports.

SECTION 4 The Deductible Stage

[Plans with no deductible replace Section 4 title with: There's no deductible for [insert 2027 plan name].]

[Plans with no deductible replace text below with: There's no deductible for [insert 2027 plan name]. You begin in the Initial Coverage Stage when you fill your first prescription for the year. Go to Section 5 for information about your coverage in the Initial Coverage Stage.]

Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage doesn't apply to most members. If you get Extra Help, this payment stage doesn't apply to you.

[If not applicable, omit information about the LIS Rider.] Look at the separate insert (the *LIS Rider*) for information about your deductible amount.]

If you don't get Extra Help, 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're in this payment stage, **you must pay the full cost of your drugs** until you reach our plan's deductible amount, which is \$[insert deductible amount] for 2027.] [Plans with a deductible amount other than \$0, add: The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.] [Plans with a deductible on only a subset of drugs, insert: You'll 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 our plan's deductible amount. For all other drugs, you won't have to pay any deductible.]* The **full cost** is usually lower than the normal full price of the drug since our plan negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

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Once you pay \$*[insert deductible amount]* for your *[insert drug tiers if applicable]* drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

[Plans with a single coverage stage: modify this section as necessary.]

[Plans with no cost sharing in the Initial Coverage Stage: modify this section as necessary.]

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

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

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

[Plans that don't use drug tiers should omit this section.]

Every drug on our 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.]*
- *[Plans with copayment/coinsurance on tiers during the Initial Coverage Stage, insert the following if the insulin cost sharing differs from the cost sharing for other drugs on the same tier: You pay \$[xx] per month supply of each covered insulin product on this tier.] [Repeat for all drug tiers.]*

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

Your pharmacy choices

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

- *[Plans with retail network pharmacies that offer preferred cost sharing, delete this bullet and use next 2 bullets instead.]* A network retail pharmacy
- *[Plans with retail network pharmacies that offer preferred cost sharing, insert: A network retail pharmacy.]*

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- *[Plans with retail network pharmacies that offer preferred cost sharing, insert: A network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.]*
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- *[Plans without mail-order service, delete this bullet.]* Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Pharmacy Directory* *[insert direct URL to pharmacy directory]*.

Section 5.2 Your costs for a one-month supply of a covered drug

[Plans using only copayments or only coinsurance should edit this section to reflect our 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.

[Plans that don't use drug tiers, omit.] The amount of the copayment or coinsurance depends on the cost-sharing tier.

[Plans without copayments omit.] Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

[If our 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 can modify the chart to indicate the different rates. Remove columns that don't apply (e.g., preferred cost sharing or mail order). Add or remove tiers as necessary. If mail order isn't available for certain tiers, plans should insert the following text in the cost-sharing cell: Mail order isn't available for drugs in [insert tier].]

[Plans that, per the state Medicaid Agency Contract, exclusively enroll QMBs, SLMBs, QIs, or dual eligible people with full Medicaid benefits can delete columns and modify the chart as necessary to reflect our plan's drug coverage.]

Chapter 6 What you pay for Part D drugs**Your costs for a one-month supply of a covered Part D drug**

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

*[Plans that offer cost sharing for insulin that differs from the cost sharing for other drugs on the same tier, insert the following footnote: You won't pay more than \$35 *[update the cost-sharing amount, if lower than \$35]* for a one-month supply of each covered insulin product regardless of the cost-sharing tier *[modify as needed if plan offers multiple cost-sharing amounts for**

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insulins (e.g., preferred and non-preferred insulins)] [insert only if plan's benefit design includes a deductible; even if you haven't paid your deductible].]

Go to Section 8 for more information on cost sharing for Part D vaccines.

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 drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We 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 get.

Section 5.4 Your costs for a long-term (*[insert if applicable: up to a] [insert number of days]-day*) supply of a covered Part D drug

[Plans that don't offer extended-day supplies delete Section 5.4.]

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is *[insert if applicable: up to]* a *[insert number of days]-day* supply.

[If our 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 can modify the chart to indicate the different rates. Remove columns that don't apply (e.g., preferred cost sharing or mail order). Add or remove tiers as necessary. If mail order isn't available for certain tiers, plans should insert the following text in the cost-sharing cell: Mail order isn't available for drugs in [insert tier].]

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[Plans must include all its tiers in the table. If plans don't offer extended-day supplies for certain tiers, our plan should use the following text in the cost-sharing cell: A long-term supply isn't available for drugs in [insert tier].]

[Plans that, per the state Medicaid Agency Contract, exclusively enroll QMBs, SLMBs, QIs, or other full-benefit dual eligible people can delete columns and modify the chart as necessary to reflect our plan's drug coverage.]

Your costs for a long-term (*[insert if applicable: up to a [insert number of days]-day*) supply of a covered Part D drug

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

[For plans that offer insulin cost sharing different from the cost sharing applicable to the other drugs on the same tier, insert the following if these cost sharing levels are applicable: You won't pay more than [inset the applicable language: \$70 [update the cost-sharing amount, if lower than \$70] for up to a 2-month supply or \$105 [update the cost-sharing amount, if lower than \$105] for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier [modify as needed if plan offers multiple cost-sharing amounts for insulins (e.g., preferred and non-preferred insulins))] [insert only if plan's benefits design includes a deductible: , even if you haven't paid your deductible].]

Chapter 6 What you pay for Part D drugs

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$*[insert 2027 out-of-pocket threshold]*

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$*[insert 2027 out-of-pocket threshold]*. You then move to the Catastrophic Coverage Stage.

[Insert if applicable: We offer additional coverage on some prescription drugs that aren't normally covered in a Medicare Drug Plan. Payments made for these drugs don't count toward your total out-of-pocket costs.]

The *Part D EOB* that you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the \$*[insert out-of-pocket threshold]* out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

[Plans with a single coverage stage: modify this section as necessary.]

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the \$*[insert 2027 out-of-pocket threshold]* limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you stay in this payment stage until the end of the calendar year.

- *[Plans that don't cover excluded drugs under an enhanced benefit, OR plans that cover excluded drugs under an enhanced benefit but with the same cost sharing as covered Part D drugs in this stage (i.e., no cost sharing), insert the following: During this payment stage, you pay nothing for your covered Part D drugs *[insert as applicable: and for excluded drugs covered under our enhanced benefit]*.]*
- *[Plans that cover excluded drugs under an enhanced benefit with cost sharing in this stage, insert the following 2 bullets:*
 - *During this payment stage, you pay nothing for your Part D covered drugs.*
 - *For excluded drugs covered under our enhanced benefit, you pay *[insert copay or coinsurance amount]*.]*

SECTION 7 Additional benefits information

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

Chapter 6 What you pay for Part D drugs

[Plans with no cost sharing can move this section to Chapter 5.]

SECTION 8 What you pay for Part D vaccines

[Plans can revise this section as needed.]

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan’s Drug List. Our plan covers most adult Part D vaccines at no cost to you *[insert only if plan’s benefit design includes a deductible: even if you haven’t paid your deductible]*. Go to our plan’s Drug List or call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself**.
- The second part is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccine depend on 3 things:

1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).

- Most adult Part D vaccines are recommended by ACIP and cost you nothing.

2. Where you get the vaccine.

- The vaccine itself may be dispensed by a pharmacy or provided by the doctor’s office.

3. Who gives you the vaccine.

- A pharmacist or another provider may give the vaccine in the pharmacy. Or, a provider may give it in the doctor’s office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you’re in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you’ll be reimbursed the entire cost you paid.

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- Other times, when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your *[insert as appropriate: coinsurance OR copayment]* for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccine at your doctor's office.

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any *[insert as appropriate: coinsurance OR copayment]* for the vaccine (including administration) *[Only insert the following if an out-of-network differential is charged for a vaccine not identified as an adult ACIP-recommended \$0 cost-sharing vaccine: , and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)]*.

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

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your *[insert as appropriate: coinsurance OR copayment]* for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.

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- You can then ask our plan to pay our share of the cost by using the procedures in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. *[Insert as appropriate: For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance for the vaccine administration.] [Only insert the following if an out-of-network differential is charged for a vaccine that isn't an adult ACIP-recommended \$0 cost-sharing vaccine: , and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)]*

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

CHAPTER 7:

Asking us to pay *[plans with cost sharing insert: our share of]* a bill for covered medical services or drugs

[Plans with an arrangement with the state can add language to reflect that the organization isn't allowed to reimburse members for Medicaid covered benefits. Plans can't revise the chapter or section headings except as indicated.]

SECTION 1 Situations when you should ask us to pay our share for covered services or drugs

Our network providers bill our plan directly for your covered services and drugs *[plans with cost sharing delete the rest of this sentence]* – you shouldn't get a bill for covered services or drugs. If you get a bill for *[plans with cost sharing insert: the full cost of]* medical care or drugs you got, send this bill to us so that we can pay it. When you send us the bill, we'll look at the bill and decide whether the services and drugs should be covered. If we decide they should be covered, we'll pay the provider directly.

If you already paid for a Medicare service or item covered by our plan, you can ask our plan to pay you back (paying you back is often called **reimburse** you). It is your right to be paid back by our plan whenever you've paid *[insert if plan has cost sharing: more than your share of the cost]* for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter. When you send us a bill you've already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

Chapter 7 Asking us to pay *[plans with cost sharing insert: our share of]* a bill for covered medical services or drugs

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

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

- You can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill our plan.
- If you pay the entire amount yourself at the time you get the care, ask us to pay you back *[insert if our plan has cost sharing: for our share of the cost]*. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us this bill, along with documentation of any payments you made.
 - If the provider is owed anything, we'll pay the provider directly.
 - If you already paid *[insert if our plan has cost sharing: more than your share of the cost]* for the service, we'll *[insert if our plan has cost sharing: determine how much you owed and]* pay you back *[insert if our plan has cost sharing: for our share of the cost]*.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our plan directly. But sometimes they make mistakes and ask you to pay *[insert as appropriate: for your services OR more than your share of the cost]*.

- *[Plans that are zero cost-share plans or approved to exclusively enroll full-benefit dual eligible people who don't pay Parts A and B cost sharing delete this paragraph.]* You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges. *[Plans that include both members who pay Parts A and B service cost sharing and members who don't pay Parts A and B service cost sharing insert: We don't allow providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.]*
- Whenever you get a bill from a network provider *[insert if our plan has cost sharing: you think is more than you should pay]*, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, *[insert if plan has cost sharing: but feel you paid too much,]* send us the bill along with documentation of any payment you

Chapter 7 Asking us to pay *[plans with cost sharing insert: our share of]* a bill for covered medical services or drugs

made. Ask us to pay you back *[insert as appropriate: for your covered services OR for the difference between the amount you paid and the amount you owed under our plan]*.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This 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 or drugs after your enrollment date, you can ask us to pay you back *[insert if our plan has cost sharing: for our share of the costs]*. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

4. When you use an out-of-network pharmacy to fill a prescription

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back *[insert if our plan has cost sharing: for our share of the cost]*. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.5 to learn more about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

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

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't 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 *[insert if our plan has cost sharing: for our share of the cost]*. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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 the drug isn't covered for some reason.

Chapter 7 Asking us to pay *[plans with cost sharing insert: our share of]* a bill for covered medical services or drugs

- For example, the drug may not be on our plan's Drug List or it could have a requirement or restriction 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 to pay you back for *[insert if plan has cost sharing: our share of the cost of]* the drug. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay *[insert if our plan has cost sharing: for our share of the cost]* for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

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

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

[Plans can edit this section as necessary to describe its claims process.]

You can ask us to pay you back by *[If our plan allows members to submit oral payment requests, insert the following language: either calling us or]* sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records. *[Insert if applicable: **You must submit your claim to us within [insert timeframe]** of the date you got the service, item, or drug.]*

[If our plan has developed a specific form for requesting payment, insert the following language: To make sure you're 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'll help us process the information faster. *[Insert the required data needed to make a decision (e.g., name, date of services, item, etc.)]*

Chapter 7 Asking us to pay *[plans with cost sharing insert: our share of]* a bill for covered medical services or drugs

- Download a copy of the form from our website (*[insert URL]*) or call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) and ask for the form.]

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

[Insert address]

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

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay *[insert if our plan has cost sharing: for our share of the cost]* for the service or drug. If you already paid for the service or drug, we'll mail your reimbursement *[insert if our plan has cost sharing: of our share of the cost]* to you. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for *[insert if our plan has cost sharing: our share of the cost of]* the care or drug. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you we won't pay for *[plans with cost sharing insert: all or part of]* the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

CHAPTER 8:

Your rights and responsibilities

[Note: Plans can add to or revise this chapter as needed to reflect NCQA-required language or language required by state Medicaid programs.]

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. *[If applicable, plans can insert information about the availability of written materials in languages other than English.]* We can also give you materials in *[insert if required to provide materials in any non-English languages per 42 CFR § 422.2267(a): in languages other than English including <required languages> and]* braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

Chapter 8 Your rights and responsibilities

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with *[insert plan contact information]*. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services and drugs

You have the right to choose a *[insert as appropriate: primary care provider (PCP) OR provider]* in our plan's network to provide and arrange for your covered services. *[Plans can edit this sentence to add other types of providers that members can see without a referral.]* You also have the right to go to a women's health specialist (such as a gynecologist) without a referral. *[If applicable, replace previous sentence with: We don't require you to get referrals [insert if applicable: to go to network providers.]]*

You have the right to get appointments and covered services from our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 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.
- You have rights related to your 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

Chapter 8 Your rights and responsibilities

information. *[Plans are permitted to include the Notice of Privacy Practices as required under the HIPAA Privacy Rule (45 C.F.R. § 164.520).]*

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to 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 or someone you've given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
 - We are required to release health information to government agencies that are checking on quality of care.
 - Because you're a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held at our plan, and to get a copy of your records. We're 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'll 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 aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).

[Note: Plans can insert custom privacy practices.]

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

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

Chapter 8 Your rights and responsibilities

As a member of [\[insert 2027 plan name\]](#), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something isn't covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know about your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. 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 your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor

Chapter 8 Your rights and responsibilities

advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't 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, can 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're in this situation. This means *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.

Legal documents you can use to give directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or 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 call Member Services at [insert Member Services number] (TTY users call [insert TTY number]) to ask for the forms.]*
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

- The hospital will ask whether you signed an advance directive form and whether you have it with you.

Chapter 8 Your rights and responsibilities

- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital did not follow the instructions in it, you can 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 our plan is filed and then should revise the previous sentence to refer to that exhibit.]*

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we're required to treat you fairly**.

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected *and it's not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call our plan's Member Services** at *[insert Member Services number]* (TTY users call *[insert TTY number]*)
- **Call your local SHIP** at *[insert phone number(s)]*
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

[As applicable, plans can include additional bullets with contact information for Medicaid and state ombudsman programs consistent with Chapter 2, Section 6.]

Chapter 8 Your rights and responsibilities

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at *[insert Member Services number]*** (TTY users call *[insert TTY number]*)
- **Call your local SHIP at *[insert phone number(s)]***
- **Contact Medicare**
 - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at: [Medicare Rights & Protections](#))
 - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

[Plans can add information about estate recovery and other requirements mandated by the state.]

Things you need to do as a member of our plan are listed below. For questions, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.
 - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card *[insert if applicable: and your Medicaid card]* whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
 - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.

Chapter 8 Your rights and responsibilities

- If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect 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.
- *[Plans can edit as needed to reflect the costs applicable to its members.]* **Pay what you owe.** As a plan member, you're responsible for these payments:
 - *[Insert if applicable: You must pay our plan premiums.]*
 - You must continue to pay your Medicare premiums to stay a member of our plan.
 - *[Delete this bullet if plan doesn't have cost sharing.]* For most of your *[insert if plan has cost sharing for medical services: medical services or]* drugs covered by our plan, you must pay your share of the cost when you get the *[insert if plan has cost sharing for medical services: service or]* drug. *[Plans that don't disenroll members for non-payment can modify this section as needed.]*
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you** *[if a continuation area is offered, insert: **generally** here and then explain the continuation area]* **can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9A:

If you have a problem or complaint (coverage decisions, appeals, complaints)

[Applicable integrated plans, the subset of fully integrated dual eligible special need plans (FIDE SNPs) and highly integrated dual eligible special need plans (HIDE SNPs) with exclusively aligned enrollment, are required to use Chapter 9B instead of Chapter 9A.]

[Plans should remove the corresponding letter, either “A” or “B”, from whichever version of Chapter 9 our plan uses (either Chapter 9A or Chapter 9B) from the document. This includes the main table of contents, Chapter 9 cover page, and Chapter 9 table of contents.]

[Plans should ensure that the text or section heading immediately preceding each Legal Terms box is kept on the same page as the box.]

SECTION 1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on 2 things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you’d like help deciding whether to use the Medicare process or the Medicaid process, or both, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).
2. The type of problem you’re having:
 - For some problems, you need to use the **process for coverage decisions and appeals**.
 - For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Chapter 9A If you have a problem or complaint (coverage decisions, appeals, complaints)

Section 1.1 Legal terms

There are 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. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP).

Each state has a government program with trained counselors. The program isn't 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're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. *[Insert SHIP name and contact information. Plans providing SHIP contact information in an exhibit should direct members to that exhibit.]*

Medicare

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- You visit www.Medicare.gov.

You can get help and information from Medicaid

[Insert contact information for the state Medicaid agency. Plans can insert similar sections for the QIO or ombudsman.]

SECTION 3 Which process to use for your problem

Because you have Medicare and get help from Medicaid, you have different processes you can use to handle your problem or complaint. Which process you use depends on if the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, use the Medicare process. If your problem is about a benefit covered by Medicaid, use the Medicaid process. If you'd like help deciding whether to use the Medicare process or the Medicaid process, call Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)).

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

Is your problem about Medicare benefits or Medicaid benefits?

My problem is about **Medicare** benefits.

Go to **Section 4, Handling problems about your Medicare benefits.**

My problem is about **Medicaid** coverage.

Go to **Section 12, Handling problems about your Medicaid benefits.**

SECTION 4 Handling problems about your Medicare benefits

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 5, A guide to coverage decisions and appeals.**

No.

Go to **Section 11, How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

Coverage decisions and appeals

SECTION 5 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request

Chapter 9A If you have a problem or complaint (coverage decisions, appeals, complaints)

is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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 properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 6.4** for more information about Level 2 appeals for medical care.
- Part D appeals are discussed in Section 7.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

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Section 5.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*)**
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services and ask for the *Appointment of Representative* form (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf *[Plans can also insert: or on our website at *[insert website or link to form]*]*)
 - For medical care, your doctor can ask for 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.
 - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or other person to be your representative, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf *[Plans can also insert: or on our website at *[insert website or link to form]*]*.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
 - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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Section 5.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 6:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 7:** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 8:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 9:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)). You can also get help or information from your SHIP.

SECTION 6 Medical care: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting coverage for medical care or want us to pay you back for [\[insert if plan has cost sharing: our share of the cost of\]](#) your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You got medical care that you believe our plan should cover, but we said we won't pay for this care. **Make an appeal. Section 6.3.**

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4. You got and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

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, go to Sections 8 and 9. Special rules apply to these types of care.

Section 6.2 How to ask for a coverage decision**Legal Terms:**

A coverage decision that involves your medical care is called an **organization determination**.

A fast coverage decision is called an **expedited determination**.

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. 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 regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll 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'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

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Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- 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. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.***For standard coverage decisions we use the standard deadlines.***

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However**, if you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 11 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 11 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

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Section 6.3 How to make a Level 1 appeal**Legal Terms:**

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

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

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** [\[If our plan accepts oral requests for standard appeals, insert: You may also ask for an appeal by calling us.\]](#) Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** [\[If a fee is](#)

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charged, insert: We're allowed to charge a fee for copying and sending this information to you.]

Step 3: We consider your appeal, and we give you our answer.

- When we are reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
 - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
 - If you believe we *shouldn't* take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 11 for information on complaints.)

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- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage 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 Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 6.4 The Level 2 appeal process**Legal Term:**

The formal name for the independent review organization is the **Independent Review Entity**. It's sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll 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 the information about your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- 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 Part B drug.

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If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- 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 Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you it's decision in writing and explain the reasons for it.

- **If the independent 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 get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
 - Explains the decision.
 - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage you're requesting meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Tells you how to file a Level 3 appeal.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 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. Section 10 explains the Level 3, 4, and 5 appeals processes.

Section 6.5 If you're asking us to pay you back for *[insert if plan has cost sharing: our share of]* a bill you got for medical care

[Plans insert if the state DOESN'T allow members to be directly reimbursed for Medicaid benefits: We can't reimburse you directly for a Medicaid service or item. If you get a bill [Plans with cost sharing insert: that's more than your copay] for Medicaid-covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting the service or item.]

[Plans insert if the state DOES allow members to be directly reimbursed for Medicaid benefits: If you have already paid for a Medicaid service or item covered by our plan, ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid [insert if plan has cost sharing: more than your share of the cost] for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.]

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for *[Insert if plan has cost sharing: our share of]* the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care isn't covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

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If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're 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 in Section 6.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment 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 asked for to you or the provider within 60 calendar days.

SECTION 7 Part D drugs: How to ask for a coverage decision or make an appeal

Section 7.1 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 include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **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. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals**Legal Term:**

An initial coverage decision about your Part D drugs is called a **coverage determination**.

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A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 7.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get) **Ask for an exception. Section 7.2**
- *[Plans with a formulary structure (e.g., no tiers) that doesn't 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 **Ask for an exception. Section 7.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 Asking for an exception**Legal Terms:**

Asking for coverage of a drug that's not on the Drug List is a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is a **formulary exception**.

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception**.

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are *[insert as applicable: 2 OR 3]* examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** *[Plans without cost sharing delete.]* If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to *[insert as appropriate: all our drugs OR drugs in [insert exceptions tier] OR drugs in [insert exceptions tier] for brand name drugs or [insert*

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exceptions tier] for generic drugs]. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. *[Plans with a formulary structure (e.g., no tiers) that doesn't allow for tiering exceptions: omit this sentence.]* If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.
3. *[Plans with no cost sharing and plans with a formulary structure (e.g., no tiers) that doesn't 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 pay as your share of the cost of the drug.
 - 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).
 - *[Plans that have a formulary structure where all the biological products are on one tier or that don't limit its 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 a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
 - *[Plans that don't limit its 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 don't limit its 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 our plan designated one of its tiers as a specialty tier and is exempting that tier from the exceptions process, include the following language: You can't 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 tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

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Section 7.3 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 you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically 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're requesting and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. [\[Plans with a formulary structure \(e.g., no tiers\) that doesn't allow for tiering exceptions: omit this statement.\]](#) If you ask us for a tiering exception, we generally won't 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 our 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, you can ask for another review by making an appeal.

Section 7.4 How to ask for a coverage decision, including an exception**Legal term:**

A fast coverage decision is called an **expedited coverage determination**.

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet 2 requirements:

- You must be asking for a drug you didn't get yet. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.

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- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
 - Explains that we'll use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
 - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. 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 *[insert direct URL]*. Chapter 2 has contact information. *[Plans that allow members to submit coverage determination requests electronically through, for example, a secure member portal can include a brief description of that process.]* To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement**, which is the medical reasons for the exception. 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.

Step 3: We consider your request and give you our answer.***Deadlines for a fast coverage decision***

- We must generally give you our answer **within 24 hours** after we get your request.
 - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.

Chapter 9A If you have a problem or complaint (coverage decisions, appeals, complaints)

- If we don't 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.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
 - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
 - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Chapter 9A If you have a problem or complaint (coverage decisions, appeals, complaints)

Section 7.5 How to make a Level 1 appeal**Legal Terms:**

An appeal to our plan about a Part D drug coverage decision is called a plan redetermination.

A fast appeal is called an **expedited redetermination**.

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision, we made about a drug you didn't get yet, 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 7.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request.** *[If our plan accepts oral requests for standard appeals, insert: or call us.]* Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at** *([insert phone number])*. Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the CMS *Model Redetermination Request Form*, which is available on our website [\[insert direct URL\]](#). Include your name, contact information, and information about your claim to help us process your request.
- *[Plans that allow members to submit appeal requests electronically through, for example, a secure member portal can include a brief description of that process.]*
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

Chapter 9A If you have a problem or complaint (coverage decisions, appeals, complaints)

[If a fee is charged, insert: We're allowed to charge a fee for copying and sending this information to you.]

Step 3: We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all 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

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we have agreed to provide within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
 - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.

Chapter 9A If you have a problem or complaint (coverage decisions, appeals, complaints)

- If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 7.6 How to make a Level 2 appeal**Legal Term**

The formal name for the independent review organization is the **Independent Review Entity**. It is sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: 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'll 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 independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the independent review entity.
- We'll send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.** [\[If a fee is charged, insert: We're allowed to charge you a fee for copying and sending this information to you.\]](#)

Chapter 9A If you have a problem or complaint (coverage decisions, appeals, complaints)

- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all the information about your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the independent review organization agrees to give you a fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.***For fast appeals:***

- **If the independent review organization says yes to part or all of what you asked for**, we must **provide the drug coverage** that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

Chapter 9A If you have a problem or complaint (coverage decisions, appeals, complaints)

What if the independent review organization says no to your appeal?

If the independent review organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 explains the Level 3, 4, and 5 appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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 is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Chapter 9A If you have a problem or complaint (coverage decisions, appeals, complaints)

Section 8.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048).

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get 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.
- Where to report any concerns you have about quality of your hospital care.
- Your right to **ask for an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. You'll be asked to sign the written notice to show that you got it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. Keep your copy of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Chapter 9A If you have a problem or complaint (coverage decisions, appeals, complaints)

Section 8.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, 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**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. [\[Insert SHIP name and contact information. Plans providing SHIP contact information in an exhibit should direct members to that exhibit.\]](#) SHIP contact information is available in Chapter 2, Section 3.

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. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*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.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline,** you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.

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- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we'll give you a **Detailed Notice of Discharge**. This notice 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.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

- Health professionals at the Quality Improvement Organization (the reviewers) 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 can if you want to.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also 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.

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 independent review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**.
- You'll 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.

What happens if the answer is no?

- If the independent review organization says *no*, they're 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.

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- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get 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 said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to **Level 2** of the appeals process.

Section 8.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision 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.

Step 1: 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 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 the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you it's decision.***If the independent review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you got 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 independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.

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- The notice you get will tell you in writing what you can do if you want to continue with the review process.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying [insert if plan has cost sharing: our share of the cost] for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

Section 9.1 We'll tell you in advance when your coverage will be ending**Legal Term:**

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal**. Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we'll stop covering the care for you.
 - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.

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2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 9.2 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'll 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**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. [\[Insert SHIP name and contact information. Plans providing SHIP contact information in an exhibit should direct members to that exhibit.\]](#) SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) 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.)

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the

Chapter 9A If you have a problem or complaint (coverage decisions, appeals, complaints)

Notice of Medicare Non-coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) 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 can if you want to.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you it's decision.

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then **we must keep providing your covered service for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- 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, **you'll have to pay the full cost** of this care yourself.

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

- 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 a Level 2 appeal.

Section 9.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision 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.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

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

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you it's decision.***What happens if the independent review organization says yes?***

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

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.

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- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go 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'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2 (for a total of 5 levels of appeal). If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 10 Taking your appeal to Levels 3, 4 and 5

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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.** Unlike a decision at Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.

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- If we decide to appeal the decision, we'll 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 medical care 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 the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 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.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that's favorable to you. We'll decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
 - If we decide to appeal the decision, we'll 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 don't want to accept the decision, you may 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 to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get 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 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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.** 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 get the decision.
- **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 don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 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.** 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 get the decision.
- **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 don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get

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will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

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Complaint	Example
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint**Legal Terms:**

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

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

- **Calling Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll 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*

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[expedited organization/coverage determinations or reconsiderations/redeterminations.\]](#)

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

- **If possible, we'll 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.
- **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'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 11.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** 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. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 11.4 You can also tell Medicare about your complaint

You can submit a complaint about [\[insert 2027 plan name\]](#) directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

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Problems about your Medicaid benefits

SECTION 12 Handling problems about your Medicaid benefits

[Plans should add sections describing the processes available to members to pursue appeals and grievances related to Medicaid-covered services. Plans should also include descriptions of how they will assist members with navigating those processes.]

CHAPTER 9B:

If you have a problem or complaint (coverage decisions, appeals, complaints)

[Applicable integrated plans, the subset of fully integrated dual eligible special need plans (FIDE SNPs) and highly integrated dual eligible special need plans (HIDE SNPs) with exclusively aligned enrollment, are required to use Chapter 9B instead of Chapter 9A.]

[Plans should remove the corresponding letter, either “A” or “B”, from whichever version of Chapter 9 our plan uses (either Chapter 9A or Chapter 9B) from the document. This includes the main table of contents, Chapter 9 cover page, and Chapter 9 table of contents.]

[Plans should ensure that the text or section heading immediately preceding each “Legal Terms” box is kept on the same page as the box.]

[Plans should refer to its state Medicaid agency contract for any additional state requirements for timeframes or notice requirements that are more protective for the enrollee and make appropriate edits throughout Chapter 9.]

SECTION 1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you’re having:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 3 will help you identify the right process to use and what you should do.

Section 1.1 Legal terms

There are 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. To make things easier, this chapter uses more familiar words in place of some legal terms.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program isn't 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're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. *[Insert SHIP name and contact information.]*

Medicare

You can also contact Medicare for help:

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

You can get help and information from Medicaid

[Insert contact information for the state Medicaid agency. Plans can insert similar sections for the QIO or ombudsman.]

SECTION 3 Understanding Medicare and Medicaid complaints and appeals

You have Medicare and get help from Medicaid. Information in this chapter applies to **all** your Medicare and Medicaid benefits. This is called an integrated process because it combines, or integrates, Medicare and Medicaid processes.

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Sometimes the Medicare and Medicaid processes aren't combined. In those situations, use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in **Section 6.4**.

SECTION 4 Which process to use for your problem

If you have a problem or concern, read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Medicaid**.

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 5, A guide to coverage decisions and appeals**.

No.

Go to **Section 11, How to make a complaint about quality of care, waiting times, customer service, or other concerns**.

Coverage decisions and appeals

SECTION 5 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is

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considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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 properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

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- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 6.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed in Section 7 of this chapter.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 5.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services at** *[insert Member Services number]* (TTY users call *[insert TTY number]*)
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf *[Plans can also insert: or on our website at [insert website or link to form]]*.)
 - For medical care, your doctor or other health care provider can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it'll be automatically forwarded to Level 2.
 - If your doctor or other health provider asks that a service or item that you're already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
 - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.

If you want a friend, relative, or other person to be your representative, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) and ask for the *Appointment of Representative* form. (The form is also available at

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www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf *[Plans can also insert: or on our website at [\[insert website or link to form\]](#)].*) This form gives that person permission to act on your behalf. It must be signed by you and the person you want to act on your behalf. You must give us a copy of the signed form.

We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You can 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 aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines, we give the details for each of these situations:

- **Section 6:** "Medical care: How to ask for a coverage decision or make an appeal"
- **Section 7:** "Part D drugs: How to ask for a coverage decision or make an appeal"
- **Section 8:** "How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon"
- **Section 9:** "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies only to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services*)

If you're not sure which information applies to you, call Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)). You can also get help or information from your SHIP.

SECTION 6 Medical care: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting coverage for medical care or want us to pay you back for [\[insert if plan has cost sharing: our share of the cost of\]](#) your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan won't approve the medical care your doctor or other health care provider wants to give you, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You got medical care that you believe our plan should cover, but we said we won't pay for this care. **Make an appeal. Section 6.3.**
4. You got and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You're told that coverage for certain medical care you've been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

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, go to Sections 8 and 9. Special rules apply to these types of care.

Section 6.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination**.

A **fast coverage decision** is called an **expedited determination**.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, 24 hours for Part B drugs.

- 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'll 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'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
 - Explains that we'll use the standard deadlines.
 - Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
 - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- 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. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request **for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days** after we get your request. If your request is for a **Part B drug**, we'll give you an answer **within 72 hours** after we get your request.

- **However**, if you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for

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making a complaint is different from the process for coverage decisions and appeals. Go to Section 11 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However**, if you ask for more time, or if we need more that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (Go to Section 11 for information on complaints.) We'll call you as soon as we make the decision.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 6.3 How to make a Level 1 appeal

Legal Terms:

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

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

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2.

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Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** *[If our plan accepts oral requests for standard appeals, insert: You may also ask for an appeal by calling us.]* Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we'll send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We'll continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You'll also keep getting all other services or items (that aren't the subject of your appeal) with no changes.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal.** We'll give you our answer sooner if your health requires us to.

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- If you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
- If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
 - If you believe we *shouldn't* take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, go to **Section 11**.)
 - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**
- If we say no to part or all of what you asked for, we'll send you a letter.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

- If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
- If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 The Level 2 appeal process**Legal Term:**

The formal name for the independent review organization is the **Independent Review Entity**. It's sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

- If your problem is about a service or item that's usually **covered by Medicare**, we'll automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that's usually **covered by Medicaid**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you'll automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page [\[insert applicable page number\(s\)\]](#) for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that's usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that's usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after getting our plan's decision letter.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

If your problem is about a service or item Medicare usually covers:**Step 1: The independent review organization reviews your appeal.**

- We'll 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 free copy of your case file.**
- 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 the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- 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 Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- 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 Part B drug.

Step 2: The independent review organization gives you its answer.

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

- **If the independent 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 get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization
- **If the independent review organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
 - Explains the decision.
 - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Tells you how to file a Level 3 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 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. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item Medicaid usually covers:**Step 1: Ask for a Fair Hearing with the state.**

- Level 2 of the appeals process for services usually covered by Medicaid is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within** *[insert number of days for the applicable state]* **calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

[Plans or states should describe the process for Medicaid Level 2 appeals, in which members must submit the Level 2 appeal themselves.]

Step 2: The Fair Hearing office gives you its answer.

The Fair Hearing office will tell you its decision in writing and explain the reasons.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service,** we must authorize or provide the service or item within 72 hours after we get the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal,** they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.)

If the decision is no for all or part of what you asked for, you can make another appeal.

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

Go to **Section 10** for more information on your appeal rights after Level 2.

Section 6.5 If you're asking us to pay you back for [insert if plan has cost sharing: our share of] a bill you got for medical care

*[Plans insert if the state DOESN'T allow members to be directly reimbursed for Medicaid benefits: **We can't reimburse you directly for a Medicaid service or item.** If you get a bill [plans with cost sharing insert: that's more than your copay] for Medicaid-covered services and items, send the bill to us. **Don't pay the bill yourself.** We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting the service or item.]*

[Plans insert if the state DOES allow members to be directly reimbursed for Medicaid benefits: If you have already paid for a Medicaid service or item covered by our plan, ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid [insert if plan has cost sharing: more than your share of the cost] for medical services or drugs that are covered by our plan. When you send us a bill you already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.]

*[Plans insert if state allows members to be directly reimbursed for Medicaid benefits: **Asking for reimbursement is asking for a coverage decision from us**]*

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

[Plans insert if state DOESN'T allow members to be directly reimbursed for Medicaid benefits:
Asking to be paid back for something you have already paid for

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. We can't reimburse you directly for a **Medicaid** service or item. If you get a bill *[plans with cost sharing insert: that's more than your copay]* for Medicaid covered services and items, send the bill to us. **Don't pay the bill yourself.** We'll contact the health care provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or items.]

If you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a Medicaid service or item you paid for, ask us to make this coverage decision. We'll check to see if the medical care you paid for is a covered service. We'll also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** *[Plans insert if state allows members to be directly reimbursed: If the medical care is covered and you followed the rules, we'll send you the payment for [insert if plan has cost sharing: our share of] the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request.]*
- *[Plans insert if state DOESN'T allow members to be directly reimbursed: If the Medicare medical care is covered, we'll send you the payment for [insert if plan has cost sharing: our share of] the cost within 60 calendar days after we get your request.]*

If the Medicaid care that you paid a health care provider for is covered and you think we should pay the health care provider instead, we'll send your health care provider the payment for *[insert if plan has cost sharing: our share of]* the cost within 60 calendar days after we get your request.

Then you'll need to contact your health care provider to get them to pay you back. If you haven't paid for the medical care, we'll send the payment directly to the health care provider.]

- **If we say no to your request:** If the medical care isn't covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we'll not pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal.** If you make an appeal, it means you're 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 in Section 6.3. For appeals concerning reimbursement, note:

- We must give you our answer within 30 calendar days after we get your appeal.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

- If the independent review organization decides we should pay, we must send you or the provider the payment 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 asked for to you or the health care provider within 60 calendar days.

SECTION 7 Part D drugs: How to ask for a coverage decision or make an appeal

Section 7.1 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 include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **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. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

An initial coverage decision about your Part D drugs is called a **coverage determination**.

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that isn't on our plan's Drug List. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 7.2.**

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- *[Plans with a formulary structure (e.g., no tiers) that doesn't 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. **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Section 7.2 Asking for an exception**Legal Terms:**

Asking for coverage of a drug that's not on the Drug List is a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is a **formulary exception**.

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception**.

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are *[insert as applicable: 2 or 3]* examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** *[Plans without cost sharing delete]* If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to *[insert as appropriate: all 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 can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. *[Plans with a formulary structure (e.g., no tiers) that doesn't 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.

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3. *[Plans with no cost sharing and plans with a formulary structure (e.g., no tiers) that doesn't 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 pay as your share of the cost of the drug.
- 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).
 - *[Plans that have a formulary structure where all the biological products are on one tier or that don't limit its 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 a lower cost-sharing. This would be the lowest tier that contains biological product alternatives for treating your condition.
 - *[Plans that don't limit its 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 don't limit its 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 our plan designated one of its tiers as a specialty tier and is exempting that tier from the exceptions process, include the following language: You can't 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 tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 7.3 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 you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically 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're asking for and wouldn't cause more side effects or other health

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problems, we generally won't approve your request for an exception. *[Plans with a formulary structure (e.g., no tiers) that doesn't allow for tiering exceptions omit the next sentence.]* If you ask us for a tiering exception, we generally **won't** 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 our 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, you can ask for another review by making an appeal.

Section 7.4 How to ask for a coverage decision, including an exception**Legal term:**

A fast coverage decision is called an **expedited coverage determination**.

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet 2 requirements:

- You must be asking for a *drug you didn't get yet*. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- 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'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
 - Explains that we'll use the standard deadlines.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

- Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. 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 [\[insert direct URL\]](#). Chapter 2 has contact information. [\[Plans that allow members to submit coverage determination requests electronically through, for example, a secure member portal can include a brief description of that process.\]](#) To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement**, which is the medical reason for the exception. 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.

Step 3: We consider your request and give you our answer.***Deadlines for a fast coverage decision***

- We must generally give you our answer **within 24 hours** after we get your request.
 - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must give you our answer **within 72 hours** after we get your request.
 - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll 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 get your request.

If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for**, we are also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Section 7.5 How to make a Level 1 appeal**Legal Terms:**

An appeal to our plan about a Part D drug coverage decision is called a **plan redetermination**.

A fast appeal is called an **expedited redetermination**.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision we made about a drug you didn't get yet, 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 7.4.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request.** [\[If our plan accepts oral requests for standard appeals, insert: or call us.\]](#) Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at** [\(\[insert phone number\]\)](#). Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the CMS *Model Redetermination Request Form*, which is available on our website [\[insert direct URL\]](#). Include your name, contact information, and information about your claim to help us process your request.
- [\[Plans that allow members to submit appeal requests electronically through, for example, a secure member portal can include a brief description of that process.\]](#)
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all 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.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
 - If we don't give you a decision within 7 calendar days, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
 - If we don't 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.
- **If our answer is yes to part or all of what you asked for**, we are also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Legal Term

The formal name for the independent review organization is the **Independent Review Entity**. It is sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: 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'll 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 independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll 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.**
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

- If the independent review organization agrees to give you a fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you have already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.***For fast appeals:***

- **If the independent review organization says yes to part or all of what you asked for**, we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If the independent organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.

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- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** talks more about the process for Level 3, 4, and 5 appeals.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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 is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

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1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get 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.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **ask for an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we'll cover your hospital care for a longer time.

2. You'll be asked to sign the written notice to show that you got it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. Keep your copy of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 8.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover inpatient hospital services for a longer time, 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**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*). Or call your State Health Insurance Assistance Program (SHIP), for personalized help. *[Insert SHIP name and contact information. Plans providing SHIP contact information in an exhibit*

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[should direct members to that exhibit.\]](#) SHIP contact information is available in Chapter 2, Section 3.

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. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*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.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.

Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice 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.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/medicare/forms-notice/beneficiary-notice-initiative/ffs-ma-im.

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

- Health professionals at the Quality Improvement Organization (the reviewers) 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 can if you want to.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also 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.

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 independent review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll 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.

What happens if the answer is no?

- If the independent review organization says no, they're 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 independent review organization says no to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get 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 said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to **Level 2** of the appeals process.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

Section 8.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision 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.

Step 1: 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 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 the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision.***If the independent review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you got 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 independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying [insert if plan has cost sharing: our share of the cost] for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

Section 9.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal**. Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

- 1. You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we'll stop covering the care for you.
 - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
- 2. You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it *doesn't* mean you agree** with our plan's decision to stop care.

Section 9.2 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'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at [\[insert Member Services number\]](#) (TTY users call [\[insert TTY number\]](#)). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. [\[Insert SHIP name and contact information. Plans providing SHIP contact information in an exhibit should direct members to that exhibit.\]](#) SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) 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.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

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

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) 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 can if you want to.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers told us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you its decision.

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then **we must keep providing your covered service for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say no, then **your coverage will end on the date we told you.**
- 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, **you'll 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.

- 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 a Level 2 appeal.

Section 9.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision 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.

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Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar 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 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 the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you its decision.***What happens if the independent review organization says yes?***

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

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go 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'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about the process for Level 3, 4, and 5 appeals.

SECTION 10 Taking your appeal to Levels 3, 4 and 5

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we'll 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 medical care 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 the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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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.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
 - If we decide to appeal the decision, we'll 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 don't want to accept the decision, you may 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 to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

[Plans can, at the discretion of the states in which they operate, insert a clear, brief description of the procedures (including time frames) and instructions about what members need to do if they want to file an additional appeal in the state.]

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get 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 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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.** 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 get the decision.
- **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 don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 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.** 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 get the decision.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**

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- If you decide to accept the decision that turns down your appeal, the appeals process is over.
- If you don't want to accept the decision, you may 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 to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan?

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Complaint	Example
	<ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are about the <i>timeliness</i> of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: <ul style="list-style-type: none"> • You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint**Legal Terms:**

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

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

- **Calling Member Services at [\[insert Member Services number\]](#)** (TTY users call [\[insert TTY number\]](#)) **is usually the first step.** If there's anything else you need to do, Member Services will let you know.

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- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll 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 call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) right away.** You can make the complaint at any time after you had the problem you want to complain about.

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

- **If possible, we'll 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.
- **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'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 11.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** 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. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Chapter 9B If you have a problem or complaint (coverage decisions, appeals, complaints)

Section 11.4 You can also tell Medicare *[insert as applicable: and Medicaid]* about your complaint

You can submit a complaint about *[insert 2027 plan name]* directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

[If state Medicaid agencies hear complaints, plans insert state-specific contact information here as directed by the state.]

CHAPTER 10:

Ending membership in our plan

[Plans can revise this chapter as needed if our plan will continue to provide Medicaid coverage when the member disenrolls from the Medicare plan.]

SECTION 1 Ending your membership in our plan

Ending your membership in *[insert 2027 plan name]* may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

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

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable 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.

- Call your State Medicaid Office at [\[insert state-specific Medicaid agency number\]](#) to learn about your Medicaid plan options.
- Other Medicare health plan options are available during the **Open Enrollment Period**. Section 2.2 tells you more about the Open Enrollment Period.
- **Your membership will usually end on the first day of the month after we get your request to change your plans.** Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Open Enrollment Period

You can end your membership during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7**.
- **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, with or without drug coverage.
 - Original Medicare *with* a separate Medicare drug plan
 - Original Medicare *without* a separate Medicare drug plan.
 - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

You get Extra Help from Medicare to pay for your prescription drugs: If you switch to Original Medicare and don't enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you've opted out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable 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.

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

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without drug coverage.
 - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **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. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit www.Medicare.gov.

- Usually, when you move
- [\[Revise bullet to use state-specific name, if applicable\]](#) If you have Medicaid
- If you're eligible for Extra Help paying for your Medicare drug coverage
- If we violate our contract with you
- If you're 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 only be eligible for certain Special Enrollment Periods. Chapter 5, Section 10 tells you more about drug management programs.
- **Note:** Section 2.1 tells you more about the special enrollment period for people with Medicaid.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage,
- Original Medicare *with* a separate Medicare drug plan,
- Original Medicare *without* a separate Medicare drug plan.
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable 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.

If you get Extra Help from Medicare to pay for your drug coverage drugs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Your membership will usually end on the first day of the month after your request to change our plan.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at [\[insert Member Services number\]](#)** (TTY users call [\[insert TTY number\]](#))
- Find the information in the **Medicare & You 2027** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
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Another Medicare health plan	<ul style="list-style-type: none">• Enroll in the new Medicare health plan.• You'll automatically be disenrolled from <i>[insert 2027 plan name]</i> when your new plan's coverage starts.
Original Medicare with a separate Medicare drug plan	<ul style="list-style-type: none">• Enroll in the new Medicare drug plan.• You'll automatically be disenrolled from <i>[insert 2027 plan name]</i> when your new drug plan's coverage starts.
Original Medicare without a separate Medicare drug plan	<ul style="list-style-type: none">• Send us a written request to disenroll <i>[insert if organization has complied with CMS guidelines for online disenrollment: or visit our website to disenroll online]</i>. Call Member Services at <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i>) if you need more information on how to do this.• You can also call Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048.• You'll be disenrolled from <i>[insert 2027 plan name]</i> when your coverage in Original Medicare starts.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable 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.

For questions about your *[insert state-specific name for Medicaid]* benefits, call *[insert state-specific name of Medicaid program, toll-free number, TTY, and days and hours of operation]*. *[Insert any additional state-specific resources for help with questions about the member's Medicaid benefits.]* Ask how joining another plan or returning to Original Medicare affects how you get your *[insert state-specific name for Medicaid]* coverage.

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

Until your membership ends, and your new Medicare *[insert if applicable: and Medicaid]* coverage starts, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**

- **Continue to use our network pharmacies *[insert if appropriate: or mail order]* to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 *[Insert 2027 plan name]* must end our plan membership in certain situations

***[Insert 2027 plan name]* must end your membership in our plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B
- If you're no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. *[Plans must insert rules for members who no longer meet special eligibility requirements. Plans must also adjust language for deeming continued eligibility. For example, "If you're within our plan's [Insert number 1-6. Plans can choose any length of time from one to 6 months for deeming continued eligibility, as long as they apply the criteria consistently across all members and fully inform members of the policy]-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, [Plans should specify policy regarding coverage of Medicaid benefits during the period of deemed continued eligibility, as defined in the State Medicaid Agency Contract. For example, "we won't continue to cover Medicaid benefits that are included under the applicable Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. The amount you pay for Medicare-covered services may increase during this period."]*
- *[Insert if applicable: If you don't pay your medical spenddown, if applicable]*
- If you move out of our service area
- If you're away from our service area for more than 6 months. *[Plans with visitor/traveler benefits should revise this bullet to indicate when members must be disenrolled from our plan.]*
 - If you move or take a long trip, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) to find out if the place you're moving or traveling to is in our plan's area.
 - *[Plans with grandfathered members who were outside of area prior to January 1999, insert: If you've been a member of our plan continuously before January 1999 and you were living outside of our service area before January 1999,*

you're still eligible as long as you haven't moved since before January 1999. However, if you move to another location that's outside of our service area, you'll be disenrolled from our plan.]

- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance, you have that provides drug coverage
- *[Omit if not applicable]* If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't 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's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't 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 can't 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 don't pay plan premiums must edit these bullets as necessary to reflect its 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 don't pay our plan premiums for *[insert length of grace period, which can't be less than 2 calendar months.]*
 - We must notify you in writing that you have *[insert length of grace period, which can't be less than 2 calendar months]* to pay our plan premium before we end your membership.

If you have questions or want more information on when we can end your membership, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).

Section 5.1 We can't ask you to leave our plan for any health-related reason

[insert 2027 plan name] isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 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.

CHAPTER 11:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* 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 (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

[Plans can add language describing additional categories covered under state human rights laws.] **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, 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, 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. You can also review information from the Department of Health and Human Services' Office for Civil Rights at www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*). 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 isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, *[insert 2027 plan name]*, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B

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through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

[Note: You can include other legal notices, such as a notice of member non-liability or a notice about third-party liability. These notices can only be added if they conform to Medicare laws and regulations. Plans can also include Medicaid-related legal notices.]

CHAPTER 12:

Definitions

[Plans should insert definitions as appropriate to our plan type described in the EOC. You can insert definitions not included in this model and exclude model definitions not applicable to our 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.]

[Plans with a POS option: Provide definitions of allowed amount, coinsurance and maximum charge, and prescription drug benefit manager.]

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 doesn't exceed 24 hours.

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 got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

[Plans that are zero cost-share plans or approved to exclusively enroll QMBs, SLMBs, QIs, or other full-benefit dual eligible people delete this definition.] **Balance Billing** – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of *[insert 2027 plan name]*, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

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 our 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

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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's no limit to the number of benefit periods.

Biological Product – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to “**Original Biological Product**” and “**Biosimilar**”).

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to “**Interchangeable Biosimilar**”).

Brand Name Drug – A prescription drug that's 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 that begins when you (or other qualified parties on your behalf) have spent \$*[insert 2027 out-of-pocket threshold]* for Part D covered drugs during the covered year. *[Plans that don't cover excluded drugs under an enhanced benefit, OR plans that do cover excluded drugs under an enhanced benefit but with the same cost sharing as covered Part D drugs in this stage (i.e., no cost sharing) insert the following: During this payment stage, you pay nothing for your covered Part D drugs [insert if applicable: and for excluded drugs that are covered under our enhanced benefit]]. [Plans that cover excluded drugs under an enhanced benefit with cost sharing in this stage, insert the following: During this payment stage, our plan pays the full cost for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.]*

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs *[insert if applicable: after you pay any deductibles]*.

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Complaint — The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, 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 (for example \$10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. *[Insert if plan has a premium: (This is in addition to our plan's monthly plan premium.)]* Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

[Delete if plan doesn't 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 our plan and the amount, if any, you're 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 our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

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

Covered Services – The term we use to mean all 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's 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

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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 don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes 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're 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 our plan is 30 days, then your daily cost-sharing rate is \$1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that's 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 (and if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious

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impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency Care – Covered services that are: 1) provided 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 isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (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's approved by the 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.

*[As appropriate, applicable integrated plans insert and alphabetize: **Integrated**]* **Grievance** – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who 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).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

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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 Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Integrated D-SNP – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of people eligible for both Medicare and Medicaid. These people are also known as full-benefit dually eligible people.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Institutional-Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

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Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan’s full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

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. *[Plans without a premium revise the following sentence as needed.]* Amounts you pay for our plan premiums, Medicare Part A and Part B premiums, and prescription drugs don’t 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] medical services, we also have a maximum out-of-pocket amount for certain types of services.] [Plans that include both members who pay Parts A and B service cost sharing and members who don’t pay Parts A and B service cost sharing insert: If you’re eligible for Medicare cost-sharing assistance under Medicaid, you aren’t responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.] (Note: Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum.)*

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that’s either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel its plan enrollment and switch to another Medicare Advantage plan or get 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 also available for a 3-month period after a person is first eligible for Medicare.

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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 i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). 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**.

[Insert cost plan definition only if you're a Medicare Cost Plan or there's 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-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

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 our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare 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.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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 isn't 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).

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Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they're filled at one of our network pharmacies.

Network Provider – Provider is the general term 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. **Network providers** 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. Network providers are also called **plan providers**.

*[Include if applicable: **Optional Supplemental Benefits** – Non-Medicare-covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them.]*

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

*[As appropriate, applicable integrated plans insert and alphabetize: **Integrated**]* **Organization Determination** – A decision our plan makes 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 document.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

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 2 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. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

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Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

*[Insert PACE plan definition only if there's 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 services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.]*

Part C – Go to Medicare Advantage (MA) plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan. 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 drug coverage.

[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're 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

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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 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.

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

[Plans that don't use PCPs, omit] **Primary Care** *[insert as appropriate: **Physician or Provider**]* **(PCP)** –The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization –Approval in advance to get services or certain drugs based on specific criteria. *[Plans can delete applicable words or sentences if it doesn't require prior authorization for any medical services and/or any drugs.]* Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics –Medical devices including, but 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.

Quantity Limits – A management tool that's designed to limit the use of a drug 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.

“Real-Time Benefit Tool” – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. 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. Our plan must disenroll you if you permanently move out of our 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 care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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 live 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'll 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 aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically

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necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

[This is the back cover for the EOC. Plans can add a logo and/or photographs, as long as these elements don't make it difficult for members to find and read our plan contact information.]

***[insert 2027 plan name]* Member Services**

Method	Member Services – Contact Information
Call	<p><i>[Insert phone number(s)]</i></p> <p>Calls to this number are free. <i>[Insert days and hours of operation, including information on the use of alternative technologies.]</i></p> <p>Member Services <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i>) also has free language interpreter services available for non-English speakers.</p>
TTY	<p><i>[Insert number]</i></p> <p><i>[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.]</i></p> <p>Calls to this number are free. <i>[Insert days and hours of operation.]</i></p>
Fax	<i>[Optional: insert fax number]</i>
Write	<p><i>[Insert address]</i></p> <p><i>[Note: plans can add email addresses here.]</i></p>
Website	<i>[Insert URL]</i>

[Insert state-specific SHIP name] *[If the SHIP's name doesn't 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	<i>[Insert phone number(s)]</i>
TTY	<p><i>[Insert number, if available. Or delete this row.]</i></p> <p><i>[Insert if the SHIP uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulty hearing or speaking.]</i></p>
Write	<i>[Insert address]</i>
Website	<i>[Insert URL]</i>

[Appendix A

Operational Guidance

Health Plan Management System (HPMS) Submission Instructions:

1. EOCs must be submitted in HPMS.
2. Unpopulated materials may not be submitted into HPMS. The organization must submit an EOC for each Contract/Plan Benefit Package (PBP) offered and must include all applicable premiums, cost-sharing, and benefit information in the material.

Note: Non-English language versions of previously submitted English language versions of the EOC should not be submitted in HPMS. Please refer to the Submission, Review, and Distribution of Materials (42 C.F.R. §§ 422.2261 and 423.2261) section of the MCMG for additional information regarding non-English language and alternate format materials.

3. If MAOs, PDPs or Cost Plans split the EOC into two or more files (e.g., different files for different sections), all sections must be submitted as one document/file.
4. MAOs, PDPs or Cost Plans that have consolidated plans should include, in one “zipped” file, the ANOCs for both plans being consolidated. The zipped file should be uploaded under the remaining PBP. For example, H0001 is consolidating PBP 001 into PBP 002 for CY2026. One zipped file should be uploaded into HPMS under H0001 PBP 002. This zipped file should have the ANOC for PBP 001 and the ANOC for PBP 002. For consolidated plans, the EOC should be submitted for the remaining consolidated plan. Using the example above, the EOC should be submitted for PBP 002. To help identify the zipped ANOCs, organizations must use the following naming convention for all zipped ANOC files: the Plan’s/Part D sponsor’s contract or MCE number, (i.e., “H” for MA or Section 1876 Cost Plans, “R” for Regional PPO plans (RPPOs), “S” for PDPs, or “Y” for Multi-Contract Entity (MCE) identifier) followed by an underscore; the PBP number followed by an underscore, any series of alpha numeric characters (Plan/Part D sponsor discretion) followed by an underscore; and an uppercase “M” for marketing materials (for example: H0001_001_efg456_M or H0001_002_abc123_M).
5. The “No Longer in Use” button should not be selected for EOC submissions. Plans/Part D sponsors must submit updated EOCs via the material replacement function in HPMS.

Multiple EOC Material Versions:

MAOs, PDPs, and Cost Plans are permitted to upload different versions (not corrections) of EOC materials with the original submission in one “zipped” file. For example, if a plan covers two states, the standalone EOC for both states would be submitted in one “zipped” file as the original submission.

Material Replacements:

MAOs, PDPs, and Cost Plans that change their current year EOCs (e.g., error corrections, Medicare FFS rate updates, policy updates) must submit updated materials via the material replacement function in HPMS. Refer to the MCMG, under “§§ 422.2261(d), 423.2261(d) – Standards for CMS Review,” and the HPMS Marketing Module User’s Guide for additional information regarding the material replacement function.

Note: *MAOs, PDPs, and Cost Plans that submit updated EOCs via the material replacement function to correct errors must also submit erratas for those errors in HPMS. Refer to the HPMS Memo, “Contract Year 2024 Annual Notice of Change and Evidence of Coverage Submission Requirements and Yearly Assessment,” to determine when erratas should be submitted.*

Note: *Do not submit errata sheets for updating Medicare fee-for-service (FFS) rates.]*

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