Chapter 3: Using the plan’s coverage for your health care and other covered services

**Introduction**

This chapter has specific terms and rules you need to know to get health care and other covered services with <plan name>. It also tells you about your care coordinator [Plans should replace the terms “care coordinator” with the term they use], how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "see Chapter 9, Section A, page 1." An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

[*Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template*.]

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# Information about “services,” “covered services,” “providers,” and “network providers”

Services are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. Covered services are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

Providers are doctors, nurses, specialists and other people who give you services and care. The term providers also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan**.** These providers have agreed to accept our payment [insert if plan has cost sharing: and your cost sharing amount] as full payment. [Plans may delete the next sentence if it is not applicable.] Network providers bill us directly for care they give you. When you see a network provider, you usually pay [insert as applicable: nothing **or** only your share of the cost] for covered services.

# Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan

<Plan name> covers all services covered by Medicare and Medicaid. This includes medical, behavioral health, and long term services and supports.

<Plan name> will generally pay for the health care and services you get if you follow plan rules. To be covered by our plan:

* The care you get must be a **plan benefit.** This means that it must be included in the plan’s Benefits Chart. (The chart is in Chapter 4 [plans may insert reference, as applicable] of this handbook).
* The care must be **medically necessary.** Medically necessarymeans you need services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules. [*Plans may revise the state-specific definition of “medically necessary” as appropriate and ensure that it is updated and used consistently throughout member material models.*]
* [Plans may omit or edit the PCP-related bullets as necessary, including modifying the name of the PCP.] You must have a network **primary care provider (PCP)** who has ordered the care or has told you to see another doctor**.** As a plan member, you must choose a network provider to be your PCP.
* In most cases, [insert as applicable: your network PCP **or** our plan] must give you approval before you can see someone that is not your PCP or use other providers in the plan’s network. This is called a **referral**. If you don’t get approval, <plan name> may not cover the services. You don’t need a referral to see certain specialists, such as women’s health specialists. To learn more about referrals, see page <page number>.
* You do not need a referral from your PCP for emergency care or urgently needed care or to see a woman’s health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, see page <page number>.
* To learn more about choosing a PCP, see page <page number>.
* **Note:** If this is your first time in a Medicare-Medicaid Plan, you may continue to see your current providers for the first 180 days with our plan, at no cost, if they are not a part of our network. If you changed to <plan name> from a different Medicare-Medicaid Plan, you may continue to see your current providers for the first 90 days with our plan, at no cost, if they are not a part of our network. During the transition time, our care coordinator will contact you to help you find providers in our network. After that time, we will no longer cover your care if you continue to see out-of-network providers.
* **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
* The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what emergency or urgently needed caremeans, see Section I, page <page number>.
* If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. [Plans may specify whether authorization should be obtained from the plan prior to seeking care.] In this situation, we will cover the care [insert as applicable: as if you got it from a network provider **or** at no cost to you]. To learn about getting approval to see an out-of-network provider, see Section D, page<page number>.
* The plan covers kidney dialysis services when you are outside the plan’s service area for a short time. You can get these services at a Medicare-certified dialysis facility.
* When you first join the plan, you can continue seeing the providers you see now for [plans should discuss the state’s continuity of care requirement].
* [Plans should add additional exceptions as appropriate.]

# Information about your care coordinator

[Plans should provide applicable information about care coordination, including explanations for the following subsections. Plans should replace the terms “care coordinator” and “care team” with terms they use.]

## C1. What a care coordinator is

## C2. How you can contact your care coordinator

## C3. How you can change your care coordinator

# Care from primary care provider, specialists, other network providers, and out-of-network providers

## D1. Care from a primary care provider

You must choose a primary care provider(PCP) to provide and manage your care.

**Definition of “PCP,” and what a PCP does for you**

[Plans should describe the following in the context of their plans:

What a PCP is

What types of providers may act as a PCP? [If a State allows specialists to act as a PCP, plans must inform beneficiaries of this and under what circumstances a specialist may be a PCP.]

The role of a PCP in:

* Coordinating covered services?
* Making decisions about or obtaining prior authorization, if applicable?

When a clinic can be your primary care [insert as appropriate: physician **or** provider] (RHC/FQHC)]

**Your choice of PCP**

[Plans must describe how to choose a PCP.]

**Option to change your PCP**

You may change your PCP for any reason, at any time during the year. Also, it’s possible that your PCP might leave our plan’s network. We can help you find a new PCP if the new one you have now leaves our network.

[Plans should describe how to change a PCP, 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 the request, etc.), and how the member will know if their PCP leaves the plan’s network.]

**Services you can get without first getting approval from your PCP**

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

In most cases, you will need approval from your PCP before seeing other providers. This approval is called a referral.You can get services like the ones listed below without first getting approval from your PCP:

* Emergency services from network providers or out-of-network providers.
* Urgently needed care from network providers.
* Urgently needed care from out-of-network providers when you can’t get to network providers (for example, when you are outside the plan’s service area).
* Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan’s service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)
* Flu shots [insert if applicable: hepatitis B vaccinations, and pneumonia vaccinations] [insert if applicable: as long as you get them from a network provider].
* Routine women’s health care and family planning services. This includes 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].
* Additionally, if you are eligible to get services from Indian health providers, you may see these providers without a referral.

[Plans should add additional bullets consistently formatted like the rest of this section as appropriate.]

## D2. Care from specialists and other network providers

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

* Oncologists care for patients with cancer.
* Cardiologists care for patients with heart problems.
* Orthopedists care for patients with bone, joint, or muscle problems.

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

What the role (if any) of the PCP in referring members to specialists and other providers

What the process for getting prior authorization is [Plans explain that prior authorization means that the member must get approval from the plan before getting a specific service or drug or seeing an out-of-network provider and including information about which plan entity makes the prior authorization decision (e.g., Medical Director, the PCP, or another entity).]

Who is responsible for getting the prior authorization [Plans explain, for example, if it is the PCP or the member and refer members to the Benefits Chart in Chapter 4 [plans may insert reference, as applicable] for information about which services require prior authorization.]

If selection of a PCP result in being limited to specific specialists or hospitals to which that PCP refers [For example, plans include information about subnetworks or referral circles.]

## D3. What to do when a network provider leaves our plan

A network provider you are using might leave our plan.

* If a network provider you are using leaves our plan, we will [Plans should describe how the member will be notified if a network provider they are using leaves the plan].
* If your provider leaves the plan’s network, we will allow a transition period of 90 days from date of notice if you have an ongoing course of treatment or are in your third trimester of pregnancy, including postpartum care.

If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

* Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
* We will make a good faith effort to give you at least 60 days’ notice so that you have time to select a new provider.
* We will help you select a new qualified provider to continue managing your health care needs.
* If you are undergoing medical treatment, you have the right to ask that the medically necessary treatment you are getting is not interrupted. We will work with you to ensure you continue getting the treatment you need.
* If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. [Plans should provide contact information for assistance.]

## D4. How to get care from out-of-network providers

[Plans should tell members under what circumstances they may obtain services from out-of-network providers (e.g., when providers of specialized services are not available in network). Include Medicaid out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it.]

If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid.

* We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid.
* If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
* Providers must tell you if they are not eligible to participate in Medicare.
* A provider must be enrolled as an Illinois Medicaid Provider to get paid for any Medicaid services they provide to you.

# How to get long-term services and supports (LTSS)

[Plans should provide applicable information about getting LTSS.]

# How to get behavioral health services

[Plans should provide applicable information about getting behavioral health services.]

# G. [*If applicable plans should add:* How to get self-directed care]

[Plans should provide applicable information about getting self-directed care including the following subsections.]

## G1. What self-directed care is

## G2. Who can get self-directed care (for example, if it is limited to waiver populations)

## G3. How to get help in employing personal care providers (if applicable)

# How to get transportation services

[Plans should provide applicable information about getting transportation services.]

# How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

## I1. Care when you have a medical emergency

**Definition of a medical emergency**

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

* serious risk to your health or to that of your unborn child; **or**
* serious harm to bodily functions; **or**
* serious dysfunction of any bodily organ or part; **or**
* in the case of a pregnant woman in active labor, when:
* there is not enough time to safely transfer you to another hospital before delivery.
* a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

**What to do if you have a medical emergency**

If you have a medical emergency:

* **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
* [Plans add if applicable: **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else [plans may replace “someone else” with “your care coordinator” or other applicable term] should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us.] [Plans must either provide the phone toll-free number and days and hours of operation or explain where to find the number (e.g., on the back of the plan’s Member ID Card).]

**Covered services in a medical emergency**

[Plans must include language emphasizing that Medicare and Medicaid do not provide coverage for emergency medical care outside the United States and its territories.]

[*Plans may modify the following sentence to identify whether this coverage is within the United States and its territories or world-wide emergency/urgent coverage:*]You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

[Plans that offer a supplemental benefit covering *world-wide emergency/urgent coverage or ambulance services outside of the United States or its territories*, mention the benefit here and then refer members to Chapter 4 [plans may insert reference, as applicable] for more information.]

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over.

[Plans may modify this paragraph as needed to address the post-stabilization care for your plan.] After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

**Getting** **emergency care if it wasn’t an emergency**

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You might go in for emergency care and have the doctor say it wasn’t really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor says it was not an emergency, we will cover your additional care *only* if:

* you go to a network provider, **or**

the additional care you get is considered “urgently needed care” and you follow the rules for getting this care. (See the next section.)

## I2. Urgently needed care

**Definition of urgently needed care**

Urgently neededcare is care you get for a sudden illness, injury, or condition that isn’t an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

**Urgently needed care when you are in the plan’s service area**

In most situations, we will cover urgently needed care *only* if:

* you get this care from a network provider, **and**

you follow the other rules described in this chapter.

However, if you can’t get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

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

**Urgently needed care when you are outside the plan’s service area**

When you are outside the plan’s service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

Our plan does not cover urgently needed care or any other [insert if plan covers emergency care outside of the United States: *and its territories:*  non-emergency] care that you get outside the United States.

[Plans with *world-wide emergency/urgent coverage* as a supplemental benefit, modify this section.]

I3. Care during a disaster

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

Please visit our website for information on how to obtain needed care during a declared disaster: <web address>. [*In accordance with 42 CFR 422.100(m), plans are required to include on their web page, at a minimum, information about coverage of benefits at non-contracted facilities at network cost sharing without required prior authorization; terms and conditions of payment for non-contracted providers; and each declared disaster’s start and end dates.*]

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at [*insert as applicable:* the in-network cost-sharing rate ***or*** no cost to you]*.* If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5 for more information.

# What to do if you are billed directly for services covered by our plan

If a provider sends you a bill instead of sending it to the plan, you can ask us to pay [plans with cost sharing, insert: our share of] the bill.

**You should not pay the bill yourself. If you do, the plan may not be able to pay you back.**

[Insert as applicable: If you have paid for your covered services **or** If you have paid more than your share for covered services**]** or if you have gotten a bill for [plans with cost sharing, insert: the full cost of] covered medical services, see Chapter 7 [plans may insert reference, as applicable] to learn what to do.

## J1. What to do if services are not covered by our plan

<Plan name> covers all services:

* that are medically necessary, **and**
* that are listed in the plan’s Benefits Chart (see Chapter 4 [plans may insert reference, as applicable])*,* **and**

that you get by following plan rules.

If you get services that aren’t covered by our plan, **you must pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 [plans may insert reference, as applicable] explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan’s coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

# Coverage of health care services covered when you are in a clinical research study?

## K1. Definition of a clinical research study

A clinical research study (also called a *clinical trial*) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

Once Medicare [*plans that conduct or cover clinical trials that are not approved by Medicare, insert:* or our plan]approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us [*plans that do not use PCPs may delete the rest of this sentence*]or your primary care [*insert as appropriate:* physician ***or*** provider]. The providers that give you care as part of the study do *not* need to be network providers.

[*If applicable, plans should describe Medicaid’s role in providing coverage for clinical research studies.*]

**You do need to tell us before you start participating in a clinical research study.** If you plan to be in a clinical research study, you or your care coordinator should contact Member Services to let us know you will be in a clinical trial.

K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

* 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 that is part of the research study.
* Treatment of any side effects and complications of the new care.

[*Plans that conduct or cover clinical trials that are not approved by Medicare insert:* We will pay any costs if you volunteer for a clinical research study that Medicare does not approve but that our plan approves*.*] If you are part of a study that Medicare [*plans that conduct or cover clinical trials that are not approved by Medicare, insert:* or our plan]has **not approved**, you will have to pay any costs for being in the study.

[*If applicable, plans should describe Medicaid’s role in paying for clinical research studies.*]

K3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading “Medicare & Clinical Research Studies” on the Medicare website (<https://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf>). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

# How your health care services are covered when you get care in 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.]

## L1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution.

You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

## L2. Getting care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is “non-excepted.”

* “Non-excepted” medical treatment is any care that is *voluntary* and *not required* by any federal, state, or local law.

“Excepted” medical treatment is any care that is *not* voluntary and *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

* The facility providing the care must be certified by Medicare.
* Our plan’s coverage of services is limited to *non-religious* aspects of care.
* If you get services from this institution that are provided to you in a facility, the following 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] You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

[Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Benefits Chart in Chapter 4 [plans may insert reference, as applicable]) or whether there is unlimited coverage for this benefit.]

# Durable medical equipment (DME)

## M1. DME as a member of our plan

DMEmeans certain items ordered by a provider for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of <plan name>, you [insert if the plan sometimes allows transfer of ownership to the member: usually] will not own the rented equipment, no matter how long you rent it.

[If the plan allows transfer of ownership of certain DME items to members, the plan must modify this section to explain the conditions under which and when the member can own specified DME.]

[If the plan sometimes allows transfer of ownership to the member for DME items other than prosthetics, insert: In certain situations, we will transfer ownership of the DME item to you.] Call Member Services to find out about the requirements you must meet and the papers you need to provide.]

[If your plan never allows transfers of ownership to the member (except as noted above, for example, for prosthetics), insert:Even if you had the durable medical equipment for up to 12 months in a row under Medicare before you joined our plan, you will not own the equipment.]

[Plans should modify this section as necessary to explain any additional Medicaid coverage of DME.]

## M2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicareprogram, people who rent certain types of DME own it after 13 months. In a Medicare Advantageplan, the plan can set the number of months people must rent certain types of DME before they own it.

**Note:** You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2019* Handbook. If you don’t have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1‑800‑MEDICARE (1‑800‑633‑4227), 24 hours a day, 7 days a week. TTY users should call 1‑877‑486‑2048.

You will have to make 13 payments in a row under Original Medicare or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

* you did not become the owner of the DME item while you were in our plan **and**

you leave our plan and get your Medicare benefits through Original Medicare instead of a health plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage plan payments do not count toward the 13 payments you need to make after leaving our plan.**

* You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
* There are no exceptions to this case when you return to Original Medicare or a Medicare Advantage plan.