

Centers for Medicare & Medicaid Services

2005 MA PPO Model EOC

(Note: instructions are in grey highlighted text)

EVIDENCE OF COVERAGE:

Your Medicare Health Benefits and Services as a Member of Sample Plan

January 1 – December 31, 2005

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Sample Plan Member Services:

For help or information, please call Member Services Monday through Friday, 9 AM to 5 PM. Calls to these numbers are free:

1-800-555-5555

TTY: 1-888-555-5555

Welcome to Sample Plan!

We are pleased that you've chosen Sample Plan.

Sample Plan is a PPO for people with Medicare

Now that you are enrolled in Sample Plan, you are getting your care through Sample, Inc. Sample Plan, a PPO, is offered by Sample, Inc. (**Sample Plan is *not* a “Medigap” or supplemental Medicare insurance policy.**)

This booklet explains how to get your Medicare services through Sample Plan

This booklet, together with your enrollment form [insert if applicable any reference to attachments, riders or other optional coverage selected] and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of Sample Plan. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2005, through December 31, 2005.

You are still covered by Original Medicare, but you are getting your Medicare services as a member of Sample Plan. This booklet gives you the details, including:

- What is covered in Sample Plan and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan and when you get care.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave Sample Plan, including your choices for continuing Medicare if you leave.

If you need to receive this booklet in a different format (such as in [insert examples of what formats are available, such as Spanish, large print, or audio tapes]) please call us so we can send you a copy. Section 1 of this booklet tells how to contact us.

Please tell us how we're doing

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet tells how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with Sample Plan. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

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How to contact Sample Plan Member Services

If you have any questions or concerns, please call or write to Sample Plan Member Services. We will be happy to help you. Our business hours are [Insert days of week and hours].

CALL	1-800-555-5555. This number is also on the cover of this booklet for easy reference. [Add if applicable: Calls to this number are free.] [You may also include reference to 24-hour lines here]
TTY	1-888-555-5555. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. [Add if applicable: Calls to this number are free.]
FAX	(fax numbers are optional).
WRITE	[insert address – You may also include E-mail addresses here]
VISIT	[insert street address] (optional).

How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline

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). CMS is the federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & **M**edicaid **S**ervices. The CMS contracts with and regulates Medicare Health Plans (including Sample, Inc.) and Medicare Private Fee-for-Service organizations.

Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. The TTY number is 1-877-486-2048 (you need special telephone equipment to use this number). Calls to these numbers are free.
- Use a computer to look at www.medicare.gov, the official **government website for Medicare information**. This website gives you a lot of up-to-date information about Medicare and nursing homes. It includes booklets you can print directly from your computer. It has a tool to help you compare Medicare managed care plans in your area. You can also search the “Helpful Contacts”

section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

[State-specific name of SHIP] / SHIP – an organization in your state that provides free Medicare help and information

[If your EOC is for a single state, replace all mentions of “SHIP” in heading and text with the actual name of the SHIP for that state, and adapt other parts of the text as needed to accommodate this substitution. Also, delete the first sentence of this paragraph if you are substituting the name of the SHIP.]

“SHIP” stands for State Health Insurance Assistance Program. [Select a clause: {State-specific name of SHIP} is a state organization/SHIPs are state organizations] paid by the Federal Government to give free health insurance information and help to people with Medicare. [Delete this next sentence if you are substituting the name of the SHIP]. SHIPs have different names depending on which state they are in. [{State-specific name of SHIP}/Your SHIP] can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. [{State-specific name of SHIP}/Your SHIP] has information about Medicare managed care plans and about Medigap (Medicare supplement insurance) policies. This includes information about special Medigap rights for people who have tried a Medicare Advantage plan (like Sample Plan) for the first time. (Medicare Advantage is the new name for Medicare + Choice). Section 12 has more information about your Medigap guaranteed issue rights.

You can contact [{state-specific name of SHIP}/the SHIP in your state] at [Insert name, address, and telephone number for all applicable SHIPS]. You can also find the website for [{state-specific name of SHIP}/your local SHIP] at www.medicare.gov on the web.

[{State-specific name of QIO} / Quality Improvement Organization] – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. [If EOC is for a single state, insert the following sentence and adapt as needed to give the name of the QIO in that state: In {name of state}, the QIO is called {name of QIO}]. The doctors and other health experts in [{name of QIO} / the QIO] review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency or comprehensive outpatient rehabilitation stay is ending too soon. See Section 10 for more information about complaints.

You can contact [{name of QIO}/the QIO in your state] at [name, address, and number for all applicable QIOs].

Other organizations (including Medicaid, Social Security Administration)

Medicaid agency – a state government agency that handles health care programs for people with low incomes

[You may adapt this generic discussion of Medicaid to reflect the name and features of the Medicaid program in your state or states] Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact [Insert name, address, and telephone number for all applicable state Medicaid agencies/state departments of health and social services. You may also add your Member Services contact information.]

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. The TTY number is 1-800-325-0778 (you need special telephone equipment to use this number). Calls to these numbers are free. You can also visit www.ssa.gov on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). The TTY number is 312-751-4701 (you need special telephone equipment to use this number). You can also visit www.rrb.gov on the web.

Employer (or “Group”) Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call [the employer's benefits administrator – or – Member Services] if you have any questions about your benefits, plan premiums, or the open enrollment season.

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In this section and all other parts of the EOC, it is optional to insert a cross-reference to Section 14 for any term for which you wish to include a more detailed or technical definition. Cross-references should use the following form: “(See Section 14 for a definition of “{insert term}.”)”]

What is Sample Plan?

Now that you are enrolled in Sample Plan, you are getting your Medicare through Sample, Inc. Sample Plan is offered by Sample, Inc., and is a PPO for people with Medicare. The Medicare program pays us to manage health services for people with Medicare who are members of Sample Plan. (Sample Plan is **not** a Medicare supplement policy. See Section 14 for a definition of Medicare supplement policy. Medicare supplement policies are sometimes called “Medigap” insurance policies.) Sample, Inc. provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. Sample Plan gives you all of the usual Medicare services that are covered for everyone with Medicare. [Insert the following sentence if it applies to your plan, adding more specific information if you wish: We also give you some additional services [and supplies], such as (insert specifics)].

[Adapt the wording of this paragraph to reflect how the plan is structured.] Since Sample Plan is a PPO, this means that you should get most or all of your health services from the doctors, hospitals, and other health providers that are part of Sample Plan. You may use non-plan providers to get covered services. However, if you use non-plan providers for care that is not emergency care, it may cost you more to use them. See Section 8 for more detail on why it costs less to see plan providers.

Use your plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of Sample Plan, you have a Sample Plan membership card. Here is a sample card to show what it looks like:

[Insert Membership Card Diagram here – front and back. Mark it as a sample card (for example, by superimposing the word “sample” across the card)]

During the time you are a plan member and using plan services, **you must use your plan membership card instead of your red, white, and blue Medicare card to get covered services.** (See Section 4 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but for the most part you will not use it to get services while you are a member. If you get covered services using your red, white, and blue Medicare card instead of your Sample Plan membership card while you are a plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your Sample Plan membership card with you at all times. You will need to show this card when you get covered services. [Add the following sentence if applicable, modifying as needed for accuracy: You [may/will] also need it to get your prescriptions at the pharmacy.] If your membership card is ever damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Help us keep your membership record up to date

[In the heading and in this paragraph, substitute the name you use for this file if different from “membership record”] Sample, Inc. has a file of information about you as a plan member. Doctors, hospitals, and other plan providers use this membership record to know what services are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Sample Plan coverage [Insert as appropriate: , the {Primary Care Physician/Medical Group/IPA} you chose when you enrolled], and other information. Section 9 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting Member Services know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident. [Call the number on the cover of this booklet / See Section 1 for how] to contact Member Services.

What is the geographic service area for Sample Plan?

The counties [and parts of counties] in our service area are listed below. [Optional: You may include a map of the area (in addition to listing the service area), and modify the prior sentence to refer readers to the map.]

[Insert plan service area listing. Use county name only if approved for entire county. For partially approved counties, use county name plus zip code, e.g., “County name, the following zip codes only: {xxxxx}...”]

Using plan and non-plan providers to get services covered by Sample Plan

What if you use plan providers to get your covered services?

Now that you are a member of Sample Plan, you can use plan providers to get your covered services. Your out-of-pocket costs will usually be lower if you use plan providers.

- **What are “plan providers”?** “Providers” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “plan providers” when they participate in Sample Plan. When we say that plan providers “participate in Sample Plan,” this means that we have arranged with them to coordinate or provide covered services to members of Sample Plan.
- **What are “covered services”?** “Covered services” is the general term we use in this booklet to mean all of the health care services and supplies that are covered by Sample Plan. Covered services are listed in the Benefits Chart in Section 4.

[Insert this paragraph if applicable, depending on plan arrangement.] As we explain below, you will have to choose one of our plan providers to be your PCP, which stands for Primary Care [Physician/Provider]. Your PCP will provide or arrange for most or all of your covered services.

What if you use non-plan providers to get your covered services?

“Non-plan providers,” are providers that are not part of Sample Plan. You may use non-plan providers to get your covered services. However, **your out-of-pocket costs may be higher than if you use our plan providers**. The exception is if you use non-plan providers for emergency care. See Section 8 for more detail on why it costs less to see plan providers.

[PPO Demonstrations that do not cover certain additional or supplemental services out-of-network: replace the above paragraph with the following paragraph] You may use non-plan providers to get most of your covered services. However, **your out-of-pocket costs may be higher than if you use our plan providers**. The exception is if you use non-plan providers for emergency care. See Section 8 for more detail on why it costs less to see plan providers. Certain services that we offer are not covered out-of-network. Refer to section 4 for more information on specific services not covered out-of-network.

You do not need to get a referral when you get care from non-plan providers. [PPO Demos: Insert the following sentence if appropriate for the plan] However, you do need to get prior authorization from us before you get some services from non-plan providers. Refer to Section 4 for more information on which services require prior authorization [PPO Demos: Insert the following sentence if appropriate for the plan] A penalty will apply if you do not get prior authorization for some of these services. Refer to Section 4 for more information on which services have a penalty if you do not get prior authorization.

The Provider Directory gives you a list of plan providers

[Insert the name of your provider directory, if different from “Provider Directory.” It is optional to add more detail to this paragraph that describes what information is available in your Provider Directory, on

your website, or from Member Services.] Every year as long as you are a member of Sample Plan, we will send you [either] a Provider Directory [or an update to your Provider Directory], which gives you a list of plan providers. If you don't have the Provider Directory, you can get a copy from Member Services [(call the number on the cover of this booklet/see Section 1 for how to contact Member Services)]. [You may also note that a complete list of plan providers is available on your website (give website address)]. You can ask Member Services for more information about plan providers, including their qualifications and experience. [It is optional to add this sentence if it applies to the plan, modifying the wording as needed for accuracy: Member Services can give you the most up-to-date information about changes in plan providers and about which ones are accepting new patients.]

Access to care and information from plan providers

You have the right to get timely access to plan providers and to all services covered by the plan. ("Timely access" means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 9 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

[PPO Demonstrations that use PCPs insert the following section.]

Choosing Your PCP (PCP means Primary Care [Provider/Physician])

What is a "PCP"?

When you become a member of Sample Plan, you must choose a plan provider to be your PCP. Your PCP is a [Adapt this list of possibilities as needed: physician, nurse practitioner, health care professional] who meets State requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. For example, in order to see a plan specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a plan specialist).

[Note: PPO Demonstrations that offer financial incentives to encourage members to choose a PCP (such as lower copays) must describe those incentives here].

How do you choose a PCP?

[Explain how a member chooses a PCP, e.g., by using the Provider Directory or getting help from Member Services. The explanation should cover how the members communicate their choice to the plan and how the plan responds. It should state that members can change PCPs (as explained later in this section). Include the following sentence in your explanation if it applies to the plan, adapting the wording as needed for accuracy: "If there is a particular Sample Plan specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital." Add the following sentence if it applies to your plan: "The name and office telephone number of your PCP is printed on your membership card."]

[PPO Demonstrations that use PCPs should insert the section on "Getting care from your PCP."]

Getting care from your PCP

You will usually see your PCP first for most of your routine health care needs. As we explain below and

in Section 4, there are only a few types of covered services you can get on your own, without contacting your PCP first. You do not need to get a referral from your PCP when you get care from non-plan providers.

Besides providing much of your care, your PCP will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from plan doctors who are specialists, hospital admissions, and follow-up care. “Coordinating” your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a plan specialist). In some cases, your PCP will [also] need to get prior authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your new PCP’s office. Section 9 tells how we will protect the privacy of your medical records and personal health information.

What if you need medical care when your doctor’s [PPO Demonstrations that use PCPs insert “PCP’s”] office is closed?

What to do if you have a medical emergency or urgent need for care

In an emergency, you should get care immediately. [PPO Demonstrations that use PCPs use the following sentence: You do **not** have to contact your PCP or get permission in an emergency.] You can dial 911 for immediate help by phone, or go directly to the nearest emergency room, hospital, or urgent care center. Section 3 tells what to do if you have a medical emergency or urgent need for care.

What to do if it is not a medical emergency

If you need to talk with your doctor [PPO Demonstrations that use PCPs use “a PCP”] or get medical care when the doctor’s [PPO Demonstrations that use PCPs use “PCP’s”] office is closed, and it is *not* a medical emergency, call [Insert the 24-hour phone number, or, if there is no 24 hour number, give directions for calling after hours. Also, adapt and expand on the rest of this paragraph, as needed, to describe what members should do to get care after hours. Include information about provisions for giving 24 hour access by phone to people with hearing impairments (such as a “relay” number the member can use to contact their PCP/Doctor after hours). If the plan has a nurse helpline, you should give its name and tell members when and how to use it]. There will always be a [doctor/plan provider/health professional] on call to help you.

See Section 3 for more information about what to do if you have an urgent need for care.

Getting care from specialists

[PPOs that do not require any referrals should start this section with the second sentence (delete first sentence).]

When your PCP thinks that you need specialized treatment, he or she will give you a referral (approval in advance) to see a plan specialist. (You do not need a referral if you are going to see a non-plan specialist) A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or

muscle conditions). Your PCP may need to get approval in advance from [Insert what is applicable: [organization name] – or – give name of specific department, such as “our Medical Management Department”] (this is called getting “prior authorization”). [If applicable, insert the following sentences instead of the prior sentence]. You may get care from specialists without a referral or prior authorization from another doctor. If you use our plan specialists, your costs for covered services will be lower than if you used non-plan providers.

[PPOs that do not require any referrals or prior authorization should not use the language in the remainder of this section]

It is very important to get a referral from your PCP before you see a plan specialist (there are a few exceptions, including routine women’s health care, that we explain later in this section). **If you don’t have a referral before you receive services from a plan specialist, you may have to pay for these services yourself.** [Modify the following sentence as needed to describe the plan’s process for referrals for follow-up specialty care]. If the plan specialist wants you to come back for more care, check first to be sure that the referral you got from your PCP covers more visits to the specialist.

[If your plan uses formal referral circles where each enrollee, by selecting a specific PCP, is also selecting an entire sub-network to which his or her PCP can make referrals, include detailed information on the nature of the sub-network, provider types, referral practices and policies. In addition, refer the beneficiary to the sub-section entitled “Choosing Your PCP,” to ensure that they know how to choose a new PCP if they are unhappy with the referral circle used by their current PCP. You may modify the wording and/or order of the sentences in the following paragraph as needed for accuracy in describing the plan’s process. In addition, it is optional to mention the Provider Directory and the information it gives about plan specialists]

If there are specific plan specialists you want to use, find out whether your PCP sends patients to these specialists. [Add whichever parts of the rest of this paragraph are applicable, modifying the wording as needed for accuracy] Each plan PCP has certain plan specialists they use for referrals. This means that **the Sample Plan specialists you can use may depend on which person you chose to be your PCP.** You can change your PCP at any time if you want to see a plan specialist that your current PCP cannot refer you to. Later in this section, under “Choosing your PCP,” we tell you how to change your PCP. If there are specific hospitals you want to use, find out whether [your PCP uses / the doctors you will be seeing use] these hospitals.

[PPOs that do not require referrals should not include the following section]

There are some services you can get on your own, without a referral

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the covered services you get as a plan member. If you get services from any plan doctor, hospital, or other health care provider without getting a referral in advance from your PCP, you may have to pay for these services yourself. *But there are a few exceptions:* you can get the following services on your own, without a referral or approval in advance from your PCP [It is optional to include either of the following two sentences.] This is called “self-refer” when you get these services on your own. You still have to pay your copayment for these services, and this includes the cost sharing associated with services provided by a non-plan provider, if applicable.

- Routine women’s health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams. You will have to pay more for these services if you do not get them from a plan provider.

- Flu shots [insert if appropriate: and pneumonia vaccinations] (you will have to pay more if you do not use a plan provider).
- Covered care from non-plan providers. [PPO Demos add the following, if appropriate for the plan “, unless you have to get prior authorization. (Refer to Section 4 for information on what services require prior authorization)”].
- [Insert any other services for which self-referrals are allowed, indicating whether or not the care must be from plan providers.]
- Emergency services, whether you get these services from plan providers or non-plan providers (see Section 3 for more information).
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan’s service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the plan providers are temporarily unavailable or inaccessible. (See Section 3 for more information about urgently needed care. Earlier in this section, we explain the plan’s service area.)
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan’s service area. [You may insert requests here, e.g., if possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area]

Getting care when you travel or are away from the plan’s service area

[If your plan offers traveler benefits to members who are out of your service area, adapt and expand the following paragraphs as needed to describe the traveler benefits and rules related to receiving the out-of-area coverage.]

You can get care when you are outside the service area. You will usually pay higher costs for the care because you will get your care from non-plan providers, but you will not pay extra if you are getting care for a medical emergency. See Section 3 for more information about care for a medical emergency. If you have questions about your medical costs when you travel, please call Member Services at the telephone number [on the cover of this booklet/in Section 1].

How to change your PCP PPO Demonstrations that use PCPs include this section.

You may change your PCP for any reason, at any time [If applicable, you may delete “at any time” and replace it with text that specifies limits on when the change may occur, such as “at the end of the month”]. To change your PCP, call Member Services [at the number on the cover of this booklet/at the number shown in Section 1]. [Insert one or more of the remaining sentences if applicable to the plan’s provider arrangement, modifying the wording as needed for accuracy.] When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP’s approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will [also] check to be sure the PCP you want to switch to is accepting new patients. Member Services [optional: will change your membership record to show the name of your new PCP, and] tell you when the change to your new PCP will take effect. [Optional: They will also send you a new membership card that shows the name and phone number of your new PCP.]

What if your doctor leaves Sample Plan?

Sometimes a doctor, [PPO Demonstrations that use PCPs use “PCP”] specialist, clinic, or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of Sample Plan. [PPO Demonstrations that use PCPs should include the following sentence] If your PCP leaves Sample Plan, we will let you know, and help you switch to another PCP so that you can keep getting covered services.

SECTION 3 Getting care if you have a medical emergency or an urgent need for care

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Getting urgently needed care when you are <u>in</u> the plan’s service area	14
Getting urgently needed care when you are <u>outside</u> the plan’s service area	14

What is a “medical emergency”?

A “medical emergency” is when **you reasonably believe that your health is in serious danger** -- when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. [PPO Demonstrations use PCPs should include the following sentences] **You do not need to get permission first from your PCP (Primary Care [Physician / Provider]) or other plan provider.** (Section 2 tells about your PCP and plan providers.)
- Make sure that [Insert whichever are applicable: [organization name]/ your PCP / your medical group] knows about your emergency, because [Adapt as needed: we / your PCP / your medical group] will need to be involved in following up on your emergency care. [PPO Demonstrations use PCPs should include the following sentences] You or someone else should call to tell your PCP about your emergency care as soon as possible, preferably within 48 hours. [Insert instructions – either give the number to call or explain where to get the number to call (e.g., the back of the membership card)].

Sample Plan will help manage and follow up on your emergency care [PPO Demonstrations that use PCPs should include the references to PCPs in this section. All other PPOs (including Demonstrations) should modify this section accordingly to address post-stabilization care.]

[[Organization name] or your PCP or your medical group] will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called “post-stabilization care.” [PPO Demonstrations: specify all cost sharing requirements with regard to emergency hospital admissions, including whether the in-network or out-of-network cost

sharing is required for enrollees who are stabilized and receive post-stabilization care in a non-preferred (out-of-network) hospital following an emergency situation. If the plan includes a cap on enrollee out-of-pocket costs for such services, please state the out-of-pocket maximum amount. You must clearly state any other requirements associated with a out-of-network emergency hospital admission, e.g., enrollee notification upon stabilization.] Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, [we / your PCP / your medical group] will try to arrange for plan providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the United States. [If plan benefits include a “world-wide” emergency benefit at no additional cost, substitute “anywhere in the world” for “United States” in the preceding sentence. If your plan offers a supplemental traveler’s benefit (at additional cost), state the availability of this coverage and tell members how to get more information about it].
- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health. [If plan benefits include a “world-wide” emergency benefit at no additional cost, substitute “anywhere in the world” (or other appropriate wording to reflect the breadth of coverage) for “United States” in the preceding sentence.]

What if it wasn’t really a medical emergency?

Sometimes it can be hard to know if you have a real 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 was not a medical emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in “What is a ‘medical emergency’” above). However, please note that:

- If you get any additional care after the doctor says it was *not* a medical emergency, the amount of the covered additional care that we pay will depend on whether you get the care from plan providers. If you get the care from plan providers, your costs will usually be lower than if you get the care from non-plan providers.
- If you get any additional care from a *non-plan provider* after the doctor says it was not a medical emergency, it will cost you more to get that care than if you see one of our plan providers. You should try to get your additional care from plan providers.

What is “urgently needed care”? (this is different from a medical emergency)

“Urgently needed care” is **when you need medical attention right away for an unforeseen illness or injury**, and it is not reasonable given the situation for you to get medical care from [PPO Demonstrations that use PCPs include “your PCP or”] other plan providers. In these cases, your health is *not* in serious danger. As we explain below, how you get “urgently needed care” depends on whether you need it when you are in the plan’s service area, or outside the plan’s service area. Section 2 tells about the plan’s service area.

What is the difference between a “medical emergency” and “urgently needed care”?

The main difference between an urgent need for care and a medical emergency is in the danger to your health. “Urgently needed care” is if you need medical help immediately, but your health is not in serious danger. A “medical emergency” is if you believe that your health is in serious danger.

Getting urgently needed care when you are in the plan’s service area

[PPO Demonstrations that use PCPs - delete references to doctors and instead refer to PCPs] If you have a sudden illness or injury that is not a medical emergency, and you are in the plan’s service area, please call your doctor or [Insert the 24-hour phone number, or, if there is no 24 hour number, give directions for calling after hours. Also, adapt and expand on the rest of this paragraph, as needed, to describe what members should do to get care after hours. Include information about provisions for giving 24 hour access by phone to people with hearing impairments (such as a “relay” number the member can use to contact their doctor after hours). If the plan has a nurse helpline, you should give its name and tell members when and how to use it]. There will always be a [doctor / plan provider / health professional] on call to help you. [Add the next two sentences, adapting as needed to reflect your plan’s policies]. Keep in mind that if you have an urgent need for care while you are in the plan’s service area, we encourage you to get this care from plan providers. You can get urgently needed care from a non-plan provider. However, using our plan providers will result in lower costs to you.

Getting urgently needed care when you are outside the plan’s service area

Sample Plan covers urgently needed care that you get from non-plan providers when you are outside the plan’s service area [insert if appropriate: (but still in the United States)]. [PPO Demonstrations that use PCPs include the following sentence] If you need urgent care while you are outside the plan’s service area, we prefer that you call your PCP first, whenever possible. [PPOs use PCPs delete “from plan providers” and insert “through your PCP”.] If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care from plan providers. [PPOs use PCPs include the following sentence] However, we will cover follow-up care that you get from non-plan providers outside the plan’s service area as long as the care you are getting still meets the definition of “urgently needed care.”

As explained in Section 2, we cover renal (kidney) dialysis services that you get when you are temporarily outside the plan’s service area (for up to six months in a row).

SECTION 4 Benefits Chart – a list of the covered services you get as a member of Sample Plan

What are “covered services”?	15
There are some conditions that apply in order to get covered services.....	15
Benefits Chart – a list of covered services (<i>note: the “Contents” in the front of this booklet gives page numbers for each of the covered services included in this chart</i>)	17-29
[Include if applicable: Extra benefits you can buy (these are called “optional supplemental benefits”)]..	29
What if you have problems getting services you believe are covered for you?	30
Can your benefits change during the year?	30
Can the prescription drugs that we cover change during the year?	30

[Adapt the cross-references and language in this introduction as needed if you use separate sheets for the benefits chart and/or cost sharing.]

What are “covered services”?

This section describes the medical benefits and coverage you get as a member of Sample Plan.

“Covered services” means the medical care, services, supplies, and equipment that are covered by Sample Plan. This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. The section that follows (Section 5) tells about **services that are not covered** (these are called “exclusions”). [Add if applicable: Section 5 also tells about **limitations** on certain services.]

[PPO Demonstrations include the following paragraph] You can get covered benefits out-of-network from any provider qualified to provide the benefit in question and who accepts the plan’s terms for payment. We urge you to call Member Services at the phone number [on the cover of this booklet/in Section 1] to ask if a particular out-of-network provider is qualified to provide any of the other plan benefits in question. Services you get from a provider that is not qualified to provide the plan benefit in question will not be covered.

[Non-PPO Demonstrations include the following paragraph] You can get covered benefits out-of-network from any provider qualified to provide the benefit in question. We urge you to call Member Services at the phone number [on the cover of this booklet/in Section 1] to ask if a particular out-of-network provider is qualified to provide any of the other plan benefits in question. Services you get from a provider that is not qualified to provide the plan benefit in question will not be covered.

[If applicable, you may mention other places where benefits, limitations, and exclusions are described, such as optional additional benefits, or addenda.]

There are some conditions that apply in order to get covered services

Some general requirements apply to all covered services

The covered services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered. [It is optional to include a definition of “medically necessary” in this paragraph and/or in Section 14. If Section 14 includes a definition of “medically necessary,” add the following sentence here: (See Section 14 for a definition of “medically necessary.”)]

In addition, some covered services require “prior authorization” in order to be covered

Some of the covered services listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets “prior authorization” (approval in advance) from [organization name or group or department that gives prior authorizations]. In these cases, you need to have prior authorization when you see plan providers. Covered services that need prior authorization are marked in the Benefits Chart. You will pay more when you get these services from a non-plan provider. [Describe how the services requiring prior authorization will be marked, i.e., by asterisk/footnote, in bold, in italics, etc.]

[Explain who is required to get the prior authorization (i.e., the doctor or the member), how the member will know that prior authorization has been granted.]

[PPO Demos: If applicable to the plan, replace the above two paragraphs with the following two paragraphs] In these cases, you need to have prior authorization regardless of whether you see plan or non-plan providers. Covered services that need prior authorization are marked in the Benefits Chart. [Describe how the services requiring prior authorization will be marked, i.e., by asterisk/footnote, in bold, in italics, etc. If some services only need prior authorization when they are received by non-plan providers, note that fact clearly in the Benefits Chart].

[Explain who is required to get the prior authorization (i.e., the doctor or the member), how the member will know that prior authorization has been granted.]

[PPO Demos: Insert if the PPO imposes a penalty for not getting prior authorization for certain services] If you do not get prior authorization for the following services, a penalty will apply: [List all services for which a penalty applies. Describe the penalty (dollar amount) for not getting prior authorization and how/if it applies in and/or out of network. Also remind the member that they have appeal rights if you impose the penalty. Reminder: the penalty for accessing non-plan services through PPO Demonstration plans can be no more than \$1,000 per item or service, which means up to \$1,000, or the Medicare allowed amount for such service, whichever is less. The Demonstration plan may not deny coverage of the service as a penalty for an enrollee’s failure to obtain the required prior authorization.]

[When preparing this Benefits Chart, please refer to the instructions contained in the cover memorandum for this Model EOC]. Note: If you offer benefits for which the coinsurance is the same percentage both in and out of network, you must make it clear that the member responsibility may be greater out of network since the coinsurance is based on the Medicare allowed amount and not the contracted amount.

Benefits Chart – a list of covered services

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
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INPATIENT SERVICES

Inpatient hospital care For more information about hospital care, see Section 7.

List days covered and any restrictions that apply. Covered services include, but are not limited to, the following:

- Semiprivate room (or a private room if medically necessary).
- Meals including special diets.
- Regular nursing services.
- Costs of special care units (such as intensive 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.
- Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy services.
- *Under certain conditions, the following types of transplants are covered:* corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 7 for more information about transplants.
- Blood - Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. [Modify as necessary if the plan begins coverage with an earlier pint]. Coverage of storage and administration begins with the first pint of blood that you need.
- Physician Services.

For both columns, List copays/coinsurance. If cost sharing is based on benefit period, include definition/explanation of ACR approved benefit period here. Also, plans that use a per admission deductible – include the following sentence] In Sample Plan, a per admission deductible is applied once during a benefit period.

Also add: If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the [insert if applicable: highest] cost sharing you would pay at a plan hospital.

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
<p>Inpatient mental health care</p> <p>Includes mental health care services that require a hospital stay. [List days covered, restrictions such as 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.]</p>	List copays/coinsurance	List copays/coinsurance
<p>Skilled nursing facility care For more information about skilled nursing facility care, see Section 7.</p> <p>[List days covered and any restrictions that apply, including whether any prior hospital stay is required.] Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> ▪ Semiprivate room (or a private room if medically necessary). ▪ Meals, including special diets. ▪ Regular nursing services. ▪ Physical therapy, occupational therapy, and speech therapy. ▪ Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). ▪ Blood - including storage and administration. Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. [Modify as necessary if the plan begins coverage with an earlier pint]. ▪ Medical and surgical supplies. ▪ Laboratory tests. ▪ X-rays and other radiology services. ▪ Use of appliances such as wheelchairs. ▪ Physician services. 	<p>For both columns, list copays / coinsurance. If cost sharing is based on benefit period, include definition/explanation of ACR approved benefit period here.</p>	
<p>Inpatient services (when the hospital or SNF days are not or are no longer covered) For more information, see Section 7.</p> <ul style="list-style-type: none"> ▪ Physician services. 		

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
<ul style="list-style-type: none"> ▪ Diagnostic tests (like X-ray or 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. ▪ Prosthetic 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>Home health care For more information about home health care, see Section 7.</p>	List copays/coinsurance	List copays/coinsurance
<p>Home Health Agency Care:</p>		
<ul style="list-style-type: none"> ▪ Part-time or intermittent skilled nursing and home health aide services. ▪ Physical therapy, occupational therapy, and speech therapy. ▪ Medical social services. ▪ Medical equipment and supplies. 		
<p>Hospice care For more information about hospice services, see Section 7.</p>	<p>When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare (see Section 7 for more information about hospice services).</p>	
<ul style="list-style-type: none"> ▪ Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. ▪ Home care. ▪ Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the hospice benefit. 		

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
OUTPATIENT SERVICES		
Physician services, including doctor office visits	List copays/coinsurance	List copays/coinsurance
<ul style="list-style-type: none"> ▪ Office visits, including medical and surgical care in a physician’s office or certified ambulatory surgical center. ▪ Consultation, diagnosis, and treatment by a specialist. ▪ Second opinion by another plan provider prior to surgery. ▪ Outpatient hospital services. ▪ Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor). 		
Also list any additional benefits offered.		
Chiropractic services	List copays/coinsurance	List copays/coinsurance
<ul style="list-style-type: none"> ▪ Manual manipulation of the spine to correct subluxation. 		
Also list any additional benefits offered.		
Podiatry services	List copays/coinsurance	List copays/coinsurance
<ul style="list-style-type: none"> ▪ Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). ▪ Routine foot care for members with certain medical conditions affecting the lower limbs. 		
Also list any additional benefits offered.		
Outpatient mental health care (including Partial Hospitalization Services)	List copays/coinsurance	List copays/coinsurance
<p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. “Partial hospitalization” is a structured program of active treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient</p>		

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
hospitalization.		
Outpatient substance abuse services	List copays/coinsurance	List copays/coinsurance
Outpatient surgery	List copays/coinsurance	List copays/coinsurance
<p>Ambulance services</p> <p>Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.</p>	<p>List copays / coinsurance for in and out of network.</p> <p>Specify whether cost sharing applies one way or for round trips.</p>	
<p>Emergency care For more information, see Section 3. [Identify whether this coverage is within the U.S. or world-wide]</p>	<p>For both columns: List copays / coinsurance. Explain (if appropriate) that cost sharing is waived if member admitted to hospital.</p> <p>If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the [insert if applicable: highest] cost sharing you would pay at a plan hospital. [PPO Demonstrations must modify the above to specify all cost sharing requirements with regard to emergency hospital admissions, including whether the in-network or out-of-network cost sharing is required for enrollees who are stabilized and receive post-stabilization care in a non-preferred (out-of-network) hospital following an emergency situation. If the plan includes a cap on enrollee out-of-pocket costs for such services, please state the out-of-pocket maximum amount.]</p>	

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
<p>Urgently needed care For more information, see Section 3. [Identify whether this coverage is within the U.S. or world-wide]</p>	List copays/coinsurance	List copays/coinsurance
<p>Outpatient rehabilitation services (physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy)</p> <p>Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.</p>	List copays/coinsurance	List copays/coinsurance
<p>Durable medical equipment and related supplies --such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of “durable medical equipment” in Section 14)</p>	List copays/coinsurance	List copays/coinsurance
<p>Prosthetic devices and related supplies--(other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” below for more detail.</p>	List copays/coinsurance	List copays/coinsurance
<p>Diabetes self-monitoring, training and supplies-- for all people who have diabetes (insulin and non-insulin users).</p> <ul style="list-style-type: none"> ▪ Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. ▪ One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. ▪ Self-management training is covered under certain conditions. ▪ <i>For persons at risk of diabetes:</i> Fasting plasma glucose 	List copays/coinsurance	List copays/coinsurance

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
<p>tests. Contact Member Services for information on how often we will cover these tests.</p>		
<p>Also list any additional benefits offered.</p>		
<p>Medical nutrition therapy—for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by a doctor.</p>	List copays / coinsurance.	List copays / coinsurance.
<p>Outpatient diagnostic tests and therapeutic services and supplies</p>		
<ul style="list-style-type: none"> ▪ X-rays. ▪ Outpatient radiation therapy. (Note: separately list any services for which a separate copay/coinsurance applies over and above the outpatient radiation therapy copay/coinsurance.) ▪ Surgical supplies, such as dressings. ▪ Supplies, such as splints and casts. ▪ Laboratory tests. ▪ Blood - Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. [Modify as necessary if the plan begins coverage with an earlier pint]. Coverage of storage and administration begins with the first pint of blood that you need. 	List copays/ coinsurance	List copays/ coinsurance
<p>PREVENTIVE CARE AND SCREENING TESTS</p>		
<p>Bone mass measurements</p>		
<p><i>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years 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></p>	List copays/ coinsurance	List copays/ coinsurance
<p>Also list any additional benefits offered.</p>		
<p>Colorectal screening</p>		
<p><i>For people 50 and older, the following are covered:</i></p>		
<ul style="list-style-type: none"> ▪ Flexible sigmoidoscopy (or screening barium enema as an 	List copays/ coinsurance	List copays/ coinsurance

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
<p>alternative) every 48 months.</p> <ul style="list-style-type: none"> Fecal occult blood test, every 12 months. <p><i>For people at high risk of colorectal cancer, the following are covered:</i></p> <ul style="list-style-type: none"> Screening colonoscopy (or screening barium enema as an alternative) every 24 months. <p><i>For people not at high risk of colorectal cancer, the following is covered:</i></p> <ul style="list-style-type: none"> Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy. <p>Also list any additional benefits offered.</p>		
<p>Immunizations [PPOs that do not require referrals do not include the reference to referrals; PPO Demonstrations that use PCPs can use the term “PCP” instead of “doctor”.]</p> <ul style="list-style-type: none"> Pneumonia vaccine [insert if appropriate: (as explained in Section 2, you can get this service on your own, without a referral from your PCP [insert if appropriate: as long as you get the service from a plan provider]).] Flu shots, once a year in the fall or winter. As explained in Section 2, you can get this service on your own, without a referral from your doctor (as long as you get the service from a plan provider). <i>If you are at high or intermediate risk of getting Hepatitis B:</i> Hepatitis B vaccine. Other vaccines if you are at risk. <p>Also list any additional benefits offered.</p>	List copays/coinsurance	List copays/coinsurance
<p>Mammography screening (as explained in Section 2, you can get this service on your own, without a referral from your doctor [insert if appropriate: as long as you get it from a plan provider]): [PPOs that do not require referrals do not need to include the reference to referrals; PPO Demonstrations that use PCPs can use the term “PCP” instead of “doctor”]</p> <ul style="list-style-type: none"> One baseline exam between the ages of 35 and 39. 	List copays/coinsurance	List copays/coinsurance

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
<ul style="list-style-type: none"> One screening every 12 months for women age 40 and older. 		
Also list any additional benefits offered.		
<p>Pap smears, pelvic exams, and clinical breast exam (as explained in Section 2, you can get these routine women’s health services on your own, without a referral from your PCP [insert if appropriate: as long as you get the services from a plan provider]); [PPOs that do not require referrals do not need to include the reference to referrals; PPOs that do not use PCPs can use the term “doctor” instead.]</p>	List copays/coinsurance	List copays/coinsurance
<ul style="list-style-type: none"> For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months. <i>If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.</i> 		
Also list any additional benefits offered.		
Prostate cancer screening exams		
For men over age 50, the following are covered once every 12 months:	List copays/coinsurance	List copays/coinsurance
<ul style="list-style-type: none"> Digital rectal exam Prostate Specific Antigen (PSA) test 		
Also list any additional benefits offered.		
<p>Cardiovascular screening blood tests</p> <p>Cholesterol and other lipid or triglyceride level blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Contact Member Services for information on how often we will cover these tests.</p>	List copays / coinsurance.	List copays / coinsurance.

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
<p>“Welcome to Medicare” physical exam</p> <p>Note: If a plan already lists routine physical exams as an additional benefit, it may modify this following language to instead refer the member to where the benefit is fully described under “Routine Physical Exams” below.</p> <p><i>For members whose Medicare Part B coverage begins on or after January 1, 2005:</i> A one-time physical exam within the first 6 months that you have Medicare Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Does not include lab tests.</p> <p>Also list any additional benefits offered.</p>	List copays/coinsurance	List copays/coinsurance
OTHER SERVICES		
Renal Dialysis (Kidney)		
<ul style="list-style-type: none"> ▪ Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 2 and 3). ▪ Inpatient dialysis treatments (if you are admitted to a hospital for special care). ▪ Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments). ▪ Home dialysis equipment and supplies. 	List copays/coinsurance	List copays/coinsurance
<p>Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply).</p>		
<p>Drugs that are covered under Original Medicare (these drugs are covered for everyone with Medicare)</p>	<p>For both columns, List copays / coinsurance.</p>	
<p>“Drugs” includes substances that are naturally present in the body, such as blood clotting factors.</p>	<p>Add the following if there is an additional prescription drug benefit that has a benefit limit: There is no benefit limit on these drugs covered under</p>	
<ul style="list-style-type: none"> ▪ Drugs that usually are not self-administered by the patient and are injected while receiving physician 		

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
<p>services. [Insert the next sentence if applicable:] Sample Plan also covers some drugs that are “usually not self-administered” even if you inject them at home.</p> <ul style="list-style-type: none"> ▪ Drugs you take using durable medical equipment (such as nebulizers) that was authorized by Sample, Inc. ▪ Clotting factors you give yourself by injection if you have hemophilia. ▪ Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. ▪ Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. ▪ Antigens. ▪ Certain oral anti-cancer drugs and anti-nausea drugs. ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®).. ▪ Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in yourhome. 	Original Medicare.	
<p>[Insert the following if you offer additional prescription drug coverage. If the prescription drug benefit is not described later in the chart, insert text that tells where the member can get more information about this benefit.] Coverage for outpatient prescription drugs is very limited. The drugs covered under Original Medicare are generally drugs that must be administered by a health professional. In addition to the drugs listed here that are covered under Original Medicare, Sample Plan offers an outpatient prescription drug benefit. This additional benefit is described below under the heading that says, “Sample Plan Prescription Drug Benefit (Outpatient prescription drugs.)”</p>		
<p>ADDITIONAL BENEFITS</p>		
<p>[If you do not offer a prescription drug benefit, delete this subsection. If you do, you may describe the prescription drug</p>	<p>For both columns, insert a SUMMARY of the cost sharing for prescription</p>	

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
<p>benefit here in the Benefits Chart or, if there is an additional premium, you may describe it in the final subsection under the heading “Extra benefits you can buy (these are called “optional supplemental benefits”). You can also describe it on separate sheets.]</p> <p>Sample Plan Prescription Drug Benefit (outpatient prescription drugs) “Drugs” include substances that are naturally present in the body.</p> <p>[Insert this sentence if applicable, adapting the wording as needed for accuracy. It is optional to give the amount of the additional premium here: If you want the Sample Plan prescription drug benefit, you must sign up for it and pay an additional monthly plan premium [of \$____].]</p> <p>The Sample Plan prescription drug benefit covers the following:</p> <ul style="list-style-type: none"> Certain outpatient prescription drugs. Section 6 explains about the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 6 also tells about drugs that are not covered by this benefit. 	<p>drugs here and refer readers to Section 6 for more information. If the benefit has a complex structure with multiple tiers, you may give just the range of amounts for copayments here and refer readers to Section 6 for the details. If there is a benefit maximum, it must be noted in the summary.</p> <p>[PPO Demos: If applicable, specify in the out-of-network column which additional benefits are not covered out-of-network.]</p>	
<p>Dental services</p> <p>[You have the option to include “Dental Services” here, under “Additional Services”, or earlier in the Benefits chart as a medical benefit.]</p> <ul style="list-style-type: none"> Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. <p>Also list any additional benefits offered, such as routine dental care.</p>	<p>List copays/coinsurance</p>	<p>List copays/coinsurance</p>
<p>(Include if applicable) Hearing services</p> <ul style="list-style-type: none"> Diagnostic hearing exams. <p>Also list any additional benefits offered, such as routine hearing exams and hearing aids.</p>	<p>List copays/coinsurance</p>	<p>List copays/coinsurance</p>

Benefits chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
<p>(Include if applicable) Vision care</p> <ul style="list-style-type: none"> Outpatient physician services for eye care. <i>For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year</i> [Adapt this description if the plan offers more than is covered by Original Medicare] One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. <p>Also list any additional benefits offered, such as routine vision exams and glasses.</p>	List copays/coinsurance	List copays/coinsurance
(Include if applicable) Routine Physical Exams	List copays/coinsurance	List copays/coinsurance
<p>(Include if applicable) Health and wellness education programs</p> <p>[These are programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets. Programs designed to enrich the health & lifestyles of members include weight management, smoking cessation, fitness & stress management. Describe the nature of the programs here.]</p>	List copays/coinsurance	List copays/coinsurance

Extra benefits you can buy (these are called “optional supplemental benefits”)

[Include this section if you offer optional supplemental benefits in the plan. (As described in instructions, you may include this section either in the EOC or as an insert to the EOC.) Describe the optional supplemental benefits, plan rules, and procedures to be followed by members who elect the optional supplemental coverage.] [PPO Demos: If applicable, specify which optional supplemental benefits are not covered out-of-network.]

Sample Plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called “**Optional Supplemental Benefits.**” If you want these Optional Supplemental Benefits, you must sign up for them [and {you may

have to} pay an additional premium for them]

[Insert plan specific optional benefits, premiums, and rules, using a chart like the Benefits Chart above. Insert plan specific procedures on how to elect optional supplemental coverage, including application process and effective dates.]

[Insert plan specific procedures on how to discontinue optional supplemental coverage, including refund of premiums. Also insert any restrictions on members' re-applying for optional supplemental coverage (e.g., must wait until next annual enrollment period)] [Include notation that: "The optional supplemental benefits included in this section are subject to the same appeals process as any other benefits."]

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services that you believe are covered for you as a member, we want to help. Please call us at Member Services at the telephone number [on the cover of this booklet / in Section 1]. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered for you. See Section 10 for information about making a complaint.

Can your benefits change during the year?

The Medicare program has rules about when and how we can make changes in your benefits. **We can increase your benefits at any time during the calendar year** (the current calendar year is the period from January 1 through December 31, [insert year]). Here are some examples:

- If we decide to add a new benefit, this would be an increase in your benefits (even though you might have to pay something if you use the new benefit).
- If we decide to provide more of some benefit that you already have, this would be an increase in your benefits.
- If we decide to reduce the amount of a copayment, coinsurance, or plan premium, this would also be an increase in your benefits because you would be getting the same benefits for less money.

If we decide to increase any of your benefits during the calendar year, we will let you know in writing.

The Medicare program does not allow us to decrease your benefits during the calendar year. We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any *decreases* we make in your benefits. We will tell you in advance (in October [insert year]) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, [insert year].

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes. In some cases, if your benefits increase, Original Medicare will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay Original Medicare out-of-pocket amounts for those services. We will let you know in advance if you will have to pay Original Medicare out-of-pocket amounts for an increased benefit.

Can the prescription drugs that we cover change during the year?

[Include this section if the plan offers an additional drug benefit that uses a formulary] **The Medicare program allows us to make changes in our prescription drug formulary list at any time during the calendar year.** As we explain in Section 6, the formulary is a list of drugs. A change in our drug formulary list could affect [Adapt the rest of this sentence as needed to reflect how the prescription drug benefit is structured: [which drugs are covered for you] –or- [how much you have to pay when you fill a covered prescription]]. Note that the formulary list applies only to the covered services listed in the Benefits Chart under the heading that says, “Sample Plan Prescription Drug Benefit (outpatient prescription drugs).”

Section 5 Medical care and services that are **NOT** covered (list of exclusions and limitations)

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What services are not covered by Sample Plan?	32

Introduction

The purpose of this section is to tell you about medical care and services that are not covered (“excluded”) or are limited by Sample Plan. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered (appeals are discussed in Sections 10 and 11).

What services are not covered by Sample Plan?

[You may add references to optional supplemental benefits where applicable, using the following format: However, [this item / these items] are available under Optional Supplemental Benefits. See the end of Section 4 for a discussion about how you can buy Optional Supplemental Benefits.]

In addition to any exclusions or limitations described in the Benefits Chart in Section 4, or anywhere else in this booklet [Add mention of other places where exclusions are given, such as addenda], **the following items and services are not covered by Sample Plan:**

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered in Section 4.
2. [PPOs that require referrals adapt wording as needed to reflect the way the plan is structured] Services from plan providers that you get without a referral from your PCP, when a referral from your PCP is required for getting that service.
3. [Adapt wording as needed to reflect the way the plan is structured] Services that you get from plan providers without prior authorization, when prior authorization is required for getting that service. [PPO Demos: Insert the following sentence if applicable] Also note that penalties will apply if you get services from non-plan providers without prior authorization, when prior authorization is required for getting that service. (Section 4 gives a definition of prior authorization and tells which services require prior authorization.)

[The services listed in the remaining bullets are excluded from the Original Medicare benefit package. If any services below are covered as additional or supplemental benefits, delete them from this list.]

4. Services that are not reasonable and necessary under Original Medicare program standards, unless otherwise listed as a covered service. As noted in Section 4, we provide all covered services according to Medicare guidelines.
5. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 3 for more information about getting care for a medical emergency).
6. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Sample, Inc. and Original Medicare to not be generally accepted by the medical community. See Section 7 for information about participation in clinical trials while you are a member of Sample Plan.
7. Surgical treatment of morbid obesity *unless* medically necessary and covered under Original Medicare.
8. Private room in a hospital, *unless* medically necessary.
9. Private duty nurses.
10. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
11. Nursing care on a full-time basis in your home.
12. Custodial care is not covered by Sample Plan *unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
13. Homemaker services.
14. Charges imposed by immediate relatives or members of your household.
15. Meals delivered to your home.
16. Unless medically necessary, elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.
17. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
18. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.
19. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine, as outlined in Section 4) and is limited according to Medicare

guidelines.

20. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
21. Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under “Outpatient Medical Services”).
22. Supportive devices for the feet. *There is an exception:* orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under “Outpatient Medical Services”).
23. Hearing aids and routine hearing examinations.
24. Routine eye examinations and eyeglasses (*except* after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.

[Since Original Medicare generally does not cover prescription drugs that are usually self-administered, exclusion #26 is provided if you offer an outpatient prescription drug benefit, but do not cover these particular types of medication and therefore need to list them in the EOC].

25. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.
26. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
27. Acupuncture.
28. Naturopaths' services.

[If you have received a waiver from CMS to exclude the limited abortion services covered by Original Medicare, you are required to provide the disclaimer that appears in the bullet point below. You are also required to list the specific services you will not provide and an alternative method (telephone number) for obtaining information on the covered services that you will not provide based on moral or religious grounds. Please contact your CMS Central Office Plan Manager for additional information]

29. Counseling or referral services which Sample, Inc. objects to based on moral or religious grounds. The law requires us to tell our current and prospective members about specific counseling and referral services that are normally part of the Medicare benefit package, but which we do not provide due to objections based on moral or religious grounds. In the case of Sample, Inc., we will not provide counseling or referral services related to [enter the benefits for which you will not provide counseling or referral services, e.g., advance directives related to withholding nutrition/treatment, etc.]. To the extent these services are covered by Medicare, they will be covered under Original Medicare.
30. Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under Sample Plan, we will reimburse veterans for the difference. Members are

still responsible for the Sample Plan cost sharing amount.

Section 6 Prescription drugs (this section gives additional information about the outpatient prescription drug benefit that is listed in the Benefits Chart in Section 4)

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[Insert if appropriate: If you want this prescription drug benefit, you must sign up for it and pay an additional premium each month].....	35
With few exceptions, your prescriptions must be from plan providers and must be filled at a plan pharmacy [or through our mail order service].....	36
Sample Plan has a list of selected [[brand name and] [generic] drugs called the “formulary”	36
How much do you pay when you fill a prescription?	38
Important things to know about [the formulary list and] how much you pay.....	39
There is a [yearly / quarterly / monthly] limit on how much we pay toward your covered prescriptions..	41
Filling your prescriptions at a plan pharmacy [or through our mail order service].....	43
Prescription drug benefit exclusions (drugs that are not covered).....	44
How to get help with questions or problems related to your prescription drug coverage	44
[Optional for exclusive card sponsors] Medicare-approved discount drug card program.....	45

[If you have a special name for the prescription drug benefit, you may substitute that name in this section. Also, if you do not offer a prescription drug benefit, you may exclude this section entirely and remove reference to it from the Table of Contents].

Introduction to the Sample Plan outpatient prescription drug benefit

The purpose of this section is to give details about the Sample Plan outpatient prescription drug benefit [Delete this last part of the sentence if the prescription drug benefit is included with no additional premium: for the members who have signed up for this extra benefit and pay the extra premium for it each month]. [Modify this sentence as needed for accuracy if the benefit is described someplace other than in the Benefits Chart in Section 4: This benefit is listed in the Benefits Chart in Section 4 under the heading, “Sample Plan prescription drug benefit (outpatient prescription drugs).”] This benefit covers certain drugs that require a prescription and that have been approved by the Food and Drug Administration (FDA).

If you want this prescription drug benefit, you must sign up for it and pay an additional premium each month

[Delete this subsection if the prescription drug benefit is included with no additional premium]

If you want the Sample Plan prescription drug benefit, you must sign up for it and pay an additional monthly plan premium [of \$_____]. [If the amount of the extra premium is given in an insert or other document, tell readers how to get it]. To sign up, [Insert instructions on how to sign up and any rules or restrictions that apply].

With few exceptions, your prescriptions must be from plan providers and must be filled at a plan pharmacy [or through our mail order service]

[Delete all references to mail order service if you do not have one. Modify the text and heading of this subsection as needed for accuracy in describing how the benefit is structured (for example, if the plan's policies are less restrictive than what this model language describes).]

[When applicable, depending on plan benefits, delete the first sentence of this paragraph and begin with the word “you” in the second sentence] In nearly all cases, your prescriptions are covered only if they are written or ordered by a plan doctor or other plan provider. In addition, as we explain later on, you must fill your prescriptions at certain pharmacies or through our own mail order pharmacy service. [Include the next sentence if applicable, adapting as needed: (Refills of certain drugs are covered only if you get them through our mail order service)]. There is an exception for medical emergencies and urgently needed care. [In the following sentence, when applicable depending on plan benefits, delete “prescriptions you get from doctors who are not plan providers and”] If it is a medical emergency or urgently needed care, we cover prescriptions you get from doctors who are not plan providers and prescriptions that are filled at non-plan pharmacies. Section 3 tells about care for a medical emergency and urgently needed care.

[If the plan has no formulary but distinguishes between brand and generic drugs for cost sharing, move the definitions and subsequent discussion of “generic” and brand-name” drugs to the subsection on “how much do you pay..”, then delete the remainder of this subsection (all parts that refer to the formulary). If the plan has no formulary and does not distinguish between brand and generic drugs, delete entire subsection].

Sample Plan has a list of [selected] [brand-name and generic / generic] drugs called the “formulary”

[Note that the model language in this section deliberately uses the term “formulary list” rather than “formulary” as an aid to understanding, because consumer testing showed that “formulary” was an unfamiliar and difficult word for beneficiaries who participated in the testing. If the plan has a special name for the formulary, you may substitute that name for the word “formulary” and “formulary list.” You may also insert further explanation or terminology related to the formulary anywhere in this subsection (such as calling it a preferred list of drugs).]

The Sample Plan formulary is a list of prescription drugs [It is optional to add the following phrase in parentheses, and you may insert other examples instead of or in addition to insulin: (including insulin)] that plan doctors refer to when they need to prescribe drugs. [Use either “Often ... but” or “Sometimes ... and” in the following sentence: [Often / Sometimes] they prescribe drugs that are included on the formulary list, [but / and] sometimes they prescribe drugs that are not on the list. [Insert Option A or B, modifying it as needed for accuracy in describing the plan's benefit:

OPTION A: As we explain a little later, **whether a drug is on the formulary list or not affects how much you have to pay when you fill a prescription for a covered drug** (non-formulary drugs are covered, but you have to pay more for them).

OPTION B: As we explain a little later, **[in nearly all cases,] your prescriptions are covered only if the drug is included on the formulary list.**

The Sample Plan formulary list was created by a group of doctors and pharmacists. They picked the drugs that are on this formulary list **based on how safe and effective they are, and how much they cost**. We call the drugs that are on this list “formulary drugs.” We call drugs that are *not* on the list “non-formulary drugs.” **To get a copy of the formulary list**, call [Insert place and number to call, including TDD/TTY and calling hours]. [Insert if applicable: The formulary list is also available on the Sample, Inc. web site on the Internet at www [_____]. [Note: You may include more detail on their formulary development process].

The formulary list includes selected [brand-name and generic drugs / generic drugs only]

[Adapt the heading and begin this subsection with whichever of OPTIONS A through C applies, adapting the wording for the option you use and for other parts of this subsection as needed for accuracy in describing the plan’s benefit:

OPTION A: The formulary list includes selected **brand-name** drugs and **generic** drugs.

OPTION B: The formulary list includes **mostly generic drugs**. Some brand-name drugs are included when there is no generic drug version of the drug available.

OPTION C: The formulary list is limited to generic drugs only. Brand-name drugs are not included on the formulary list.

- **Brand-name drugs** are drugs that are produced and sold under the original manufacturer’s brand name.
- **Generic drugs** are produced and sold under their chemical names, rather than under the names of the companies that manufacture them. A generic drug is a lower cost version of a brand name drug. Some brand-name drugs have a generic equivalent and others do not.

Generic drugs cost less, but **generic and brand-name drugs are the same in terms of quality and how they work**. The law requires that a generic drug must contain the same amount of the same active drug ingredient as the brand-name drug. However, a generic drug may differ in certain other ways, such as its color or its flavor, the shape of the pill or tablet, and the inactive (non-drug) ingredients it contains.

[It is optional to add the following sentence if applicable, or a similar statement about cost implications for the member of getting a generic rather than a formulary drug: As we explain below, you pay less for formulary drugs if you get a generic drug rather than a brand-name drug.] [It is optional to include any parts of the rest of the following paragraph that are applicable, placing them anywhere in this subsection, adapting the wording as needed for accuracy, and expanding on the topics that are covered if you wish]

The Sample Plan formulary list includes most generic drugs. When there is a generic drug available, the formulary list usually includes only the generic drug. Sample Plan’s plan pharmacies and mail order service fill prescriptions using generic drugs rather than brand-name drugs whenever possible.

How much do you pay when you fill a prescription?

[Use whichever parts of this subsection are applicable, adapting the wording as needed for accuracy. If the plan uses a deductible and/or coinsurance instead of, or in addition to, copayments, make the necessary changes in wording in this subsection and elsewhere in the section as needed.]

The amount you pay when you fill a covered prescription is called your **copayment**. [Modify the wording of this sentence as needed for accuracy: Your copayment can vary from \$___ to \$___, depending on the drug [and on whether you get the drug at a plan pharmacy or through our mail order service].

- When you fill a prescription, you pay either the copayment listed below, or you pay the full cost of the prescription – whichever is *lower*.
- **There is a limit on how much of the drug you can get for one copayment.** For most oral medications, such as pills or other drugs that you swallow, the maximum is a [Insert number of days, such as 30 day] supply (or less than a **xx**-day supply for one copayment if your doctor orders less). [Modify the remaining sentences in this paragraph as needed for accuracy in describing how the plan limits quantities per copayment]. For medications other than ones you swallow, the maximum depends on the type of medication. The maximum amount per copayment might be a single container, inhaler unit, package, or course of therapy. For example, you would have to pay two copayments if you got two inhalers. If your doctor prescribes an amount of medication that is *smaller* than the maximum allowed for a single copayment, you must still pay the full copayment.
- If you fill the prescription through our mail order service, [Insert if applicable or modify wording to reflect your mail order service: the mail order copayment is lower than the plan pharmacy copayment, but you must order a larger supply. [Include the following text if applicable, adapting as needed for accuracy, or replace it with a brief description of mail order copayments: By mail, you can order either a 60 day supply for the cost of two mail order copayments, or a 90 day supply for the cost of three mail order copayments.]

[The following two lists of bullets provide many different options to choose among for model language to describe copayments or coinsurance. You will use only a subset of these bullets. Pick the one or ones that fit best as your starting point, and modify them as needed to produce an accurate description of the plan's cost sharing. You may delete, add to, or modify the subheadings to fit the description you supply. If you have more than one tier within one of the categories listed below (such as three tiers of copays for generic formulary drugs), either expand on the existing bullets or add more bullets to cover all of the cost sharing. If you include copayments for mail order drugs in the list below, and have a minimum for mail orders, your explanation of the copayments must make clear how minimum orders by mail affect the total copayment for a prescription filled by mail. Dollar amounts for copayments and dollar limits should be printed in boldface.]

For drugs that are included on the formulary list, here are your copayments for up to a **xx** -day supply (or whatever other amount is the maximum amount for one copayment):

- \$_____ for a **formulary drug** if you get it at a plan pharmacy. If the drug is available through our mail order service, the copayment is \$ _____ [per **xx** -day supply]. (Since the minimum order by mail is a **xx** -day supply for two copayments, you would pay a total of \$_____ for a **xx** -day supply by mail).

- \$_____ for a **generic formulary drug** if you get it at a plan pharmacy. If the drug is available through our mail order service, the copayment is \$ _____ [per xx -day supply] if you get it by mail. (Since the minimum order by mail is a xx -day supply for two copayments, you would pay a total of \$_____ for a xx -day supply by mail.)
- \$_____ for a **brand-name formulary drug** if you get it at a plan pharmacy. If the drug is available through our mail order service, the copayment is \$ _____ [per xx-day supply] if you get it by mail. (Since the minimum order by mail is a xx -day supply for two copayments, you would pay a total of \$_____ for a xx -day supply by mail.) [Add if applicable: NOTE: If you get a brand-name formulary drug when there is a generic version also available [on the formulary list], you must pay the difference between the cost of the brand-name and generic versions, *in addition to* your copayment.]

For drugs that are **not** included on the formulary list, here are your copayments for up to a xx -day supply (or whatever other amount is the maximum amount for one copayment):

- The plan's prescription drug benefit **does not cover any non-formulary drugs**, unless your doctor requests a special exception and we approve it. If an exception is approved, your copayment would be \$_____.
- Your copayment is \$___ for **any non-formulary drug** (whether it is a generic or brand-name drug). [Add the following if applicable, adapting the wording as needed for accuracy: Non-formulary drugs are not available through our mail order service].
- Your copayment is \$___ for a **generic non-formulary drug**. [Add the following if applicable, adapting the wording as needed for accuracy: Non-formulary drugs are not available through our mail order service].
- Your copayment is \$___ for a **brand-name non-formulary drug** [Add the following if applicable, adapting the wording as needed for accuracy: Non-formulary drugs are not available from our mail order service] [Add if applicable, adapting the wording as needed for accuracy: NOTE: If you get a brand-name drug when there is a generic available, you must pay the difference between the cost of the brand-name and generic versions, in addition to your \$ _____ copayment.]

[If your drug benefit has another category of drugs, besides "formulary" and non-formulary," (such as high technology drugs) identify the other category here and give the copayment(s) for drugs in this category.]

Important things to know about [the formulary list and] how much you pay

[Adapt the wording of the main heading for this subsection (above) and the subheadings below as needed for accuracy. If the plan has any rules related to formulary and/or copayments / coinsurance / deductibles that are not included in the model language in this subsection, you may add text that describes these rules anywhere in the subsection, either as a separate new part, or incorporated into an existing part.]

[Use this paragraph if the plan confines coverage primarily to drugs listed on the formulary, adapting as needed for accuracy: **In [nearly] all cases, a [drug/brand-name drug] must be on the Sample Plan formulary list in order to be covered**

[Use this model language as a starting point to explain how and why exceptions to the formulary are made. You may use part or all of the model language that is applicable, adapting the wording as needed for accuracy.] The outpatient prescription drug benefit covers the drugs that are on the formulary list. We make exceptions only under special circumstances. For example, there may be medical reasons why a [non-formulary drug/brand-name drug] is needed in place of a [formulary drug /brand-name drug]. In this situation, your doctor must get approval in advance [(this is called “prior authorization”)] from [organization name/name of drug vendor] in order for the [non-formulary drug/brand-name drug] to be covered. [Describe the plan’s criteria for exceptions by inserting an explanation of typical reasons why exceptions might be made]. If we deny a request for an exception, you have a right to appeal that request (see Section 10 for more information on appeals).

[A few / Some] [formulary] drugs are covered only if your doctor gets approval in advance to prescribe them

[Include this paragraph if applicable, adapting the text and heading as needed for accuracy. The explanation should make it clear whether prior authorization applies to formulary drugs only or can apply to non-formulary drugs as well.] Some of the drugs included in the prescription drug benefit are covered only if your doctor calls and gets approval in advance from [Identify the entity that handles prior authorizations, e.g., organization name / name of drug vendor / name of department] before prescribing the drug (this is called “prior authorization”). [Insert a brief explanation that tells when this prior authorization is typically required (such as, for which types of drugs or under which circumstances). It is optional to add a statement that tells a little about the process, such as how long prior authorization might take. Include the sentences in the rest of this paragraph if they are applicable, adapting the wording as needed for accuracy, and adding other examples if you wish] The drugs that require prior authorization are marked on the formulary list. Here is one example: if the formulary list includes both the brand-name and generic versions of a drug, you are covered for the generic version only, unless your doctor gets approval in advance to prescribe the brand-name drug instead. [If applicable, include this sentence and insert another example at the end] Here is another example: [insert example].

Since the formulary list can change during the year, there could be changes in [the drugs available to you / in what you have to pay for a particular drug]

[The following paragraph includes many phrases in brackets that may or may not be applicable. Include whichever parts are applicable, adapting as needed]

A committee of doctors and pharmacists reviews and updates the [Sample Plan] formulary list [Insert time-frame, e.g.: quarterly/regularly] throughout the year. This means that drugs can be added to or dropped from the formulary list at any time [without notice]. [Drugs can also be changed from one category of drugs to another within the formulary.] Changes in the formulary list can affect [which drugs are covered for you] [and] [[the amount of your copayment / how much you pay] when you fill a prescription.] [It is optional to explain further about the possible consequences of changes in the formulary. For example, you can insert the following two sentences, if applicable, adapting as needed for accuracy: For example, if a non-formulary drug you are using is added to the formulary list, your copayment would be lower. If a formulary drug you are using is dropped from the formulary list, your copayment would increase.] You can call [Insert instructions] to find out if your drug is on the formulary list or to get a copy of the formulary list.

[If you notify members and/or doctors about changes in the formulary, it is optional to insert an

explanation here that tells how you notify them. You may use the following sentence if applicable, adapting as needed for accuracy, or insert your own explanation: During the year, we use [insert method(s), e.g. : newsletters] to tell doctors and plan members about changes in the formulary list. [It is optional to add whichever of these next two sentences is applicable, adapting as needed: If a change in the formulary list affects one of your prescriptions, we will let you know in writing. [--or--] If a change in the formulary list affects one of your prescriptions, your doctor or pharmacist will let you know.] [If you make special exceptions for those with existing prescriptions when you change the formulary, you can insert an explanation here.]

There is a [yearly / quarterly / monthly] limit on how much we pay toward your covered prescriptions

[If there is no maximum, delete this subsection. If there is a maximum, adapt the text in this subsection as needed to reflect the way the benefit maximum is structured.]

Your **maximum prescription drug benefit** for [the calendar year/ each three-month calendar quarter / each month] is \$ _____. [If calendar year or calendar quarter, insert the definition that applies: [By “calendar year,” we mean the 12-month period from January 1 through December 31 of a given year./ By “calendar quarter,” we mean any of the following three-month periods that make up a full year: January 1 through March 31; April 1 through June 30; July 1 through September 30; October 1 through December 31.] [Explain how the maximum is applied, using either OPTION A or OPTION B as a guide to adapt as needed:]

OPTION A: This [yearly/quarterly/ monthly] maximum applies to all prescriptions covered by the Sample Plan prescription drug benefit. This maximum does *not* apply to drugs covered under Original Medicare, which are the drugs that are covered for everyone with Medicare (such as drugs you are given in the hospital – see Section 4).

OPTION B: The [yearly/quarterly/monthly] maximum applies *only* to prescriptions for [brand-name drugs and non-formulary drugs] covered by the Sample Plan prescription drug benefit. It does *not* apply [to generic formulary drugs or] to drugs covered under Original Medicare (which are the drugs that are covered for everyone with Medicare, such as drugs you are given in the hospital – see Section 4).

[Insert the following if applicable, adapting as needed: If you join Sample Plan on or after [insert date], the \$_____ maximum will be adjusted during your first year of membership only. For more information about this, call [insert number].]

What we pay for your drugs is what counts toward your benefit limit

As shown in the following diagram, it is the payments we make as our share of the cost of your covered prescriptions [If applicable, insert types of drugs to which the maximum applies, e.g., “for brand-name and non-formulary drugs”] that count toward the [yearly / quarterly / monthly] limit on your prescription drug benefit. Outpatient drugs covered by Original Medicare (as listed in Section 4) do not count toward your benefit limit. [If the plan has a deductible and/or coinsurance, modify this subsection (text, subheadings, diagram) as needed to describe the deductible and coinsurance.]

The cost of each prescription covered by the [name of M+C plan] prescription drug benefit has **two parts**:

\$ your copayment

+

\$ [name of M+C plan]'s payment

=

\$ total cost

The amount **you** pay when you fill a covered prescription is called your “**copayment**.” [If the plan has a simple structure for copayments, it is optional to insert amounts in this diagram]. [Insert the following if appropriate]

Your copayment does not count toward your maximum benefit.

[Insert a brief reference to a deductible here, if applicable] After you have paid the copayment, **we pay the rest**. Our payments for your prescriptions [If applicable, insert types of drugs to which the maximum applies, e.g., “for brand-name and non-formulary drugs”] that are covered by the prescription drug benefit count toward the [yearly / quarterly / monthly] maximum of \$____.

[Insert the plan’s own explanation of how cost is determined, for example: **Total cost** is the amount agreed upon by Sample, Inc. and our plan pharmacies.

What happens if you use up the \$____ prescription drug benefit before the end of the [calendar year/calendar quarter/month]?

[Use one of the following two paragraphs, whichever is appropriate for your plan.]

Once our payments reach the [yearly/quarterly / monthly] maximum of \$____, we stop paying for our share of the cost of your covered prescriptions that come under this benefit limit. Then you have to pay the full cost of your prescriptions [If applicable, insert types of drugs to which the maximum applies, e.g., “for brand-name and non-formulary drugs”] that are covered by the [plan’s prescription drug benefit] through the end of the [calendar year/calendar quarter/month].

Once our payments reach the [yearly/quarterly / monthly] maximum of \$____, we begin paying less for our share of the cost of your covered prescriptions that come under this benefit limit. Then you have to pay [explain the discount amount] for your prescriptions [If applicable, insert types of drugs to which the maximum applies, e.g., “for brand-name and non-formulary drugs”] that are covered by the [plan’s prescription drug benefit] through the end of the [calendar year/calendar quarter/month].

What happens if you do not use up the \$_____ benefit by the end of the [year / quarter / month]?

If our payments for your covered prescriptions [If applicable, insert types of drugs to which the maximum applies, e.g., “for brand-name and non-formulary drugs”] are less than the \$_____ maximum during a [calendar quarter / month], you [are/are not] allowed to “carry over” the unused portion to the next [calendar quarter / month].

How can you find out how much of your additional prescription drug benefit has been used?

[It is optional to insert additional explanation in this paragraph. For example, if your mail order service tells members the amount that the plan pays, you can mention this.] It may be hard for you to keep your own record of how much we pay for your covered prescriptions. The pharmacy will always tell you how much *you* owe, but may not give you the total cost, or tell you how much we have to pay as our share of the cost. Since we keep track of our payments for your prescriptions, you can ask us anytime to tell you how much of your \$ ____ benefit has been used. To find out [insert instructions].

Filling your prescriptions at a plan pharmacy [or through our mail order service]

Filling prescriptions at a plan pharmacy

[You may make changes that are needed for accuracy in this subsection. It is optional to add more information than is given in the model language.] To get a list of the pharmacies you can use, [insert instructions]. We call the pharmacies on this list our “plan pharmacies” because we have made arrangements with them to handle prescriptions for members of Sample Plan.

To use your prescription drug benefit, you must show your Sample Plan ID card at one of our plan pharmacies. [It is optional to include the rest of this paragraph if applicable, adapting as needed for accuracy: If you do not have your ID card with you when you fill the prescription, you will have to pay the *full cost* of the prescription (rather than paying just your copayment). If this happens to you, you can ask us to reimburse you for our share of the cost by filling out a pharmacy claim form and sending it to us. To get a claim form and more information, call [insert instructions]].

[Delete this paragraph if it does not apply to the plan]. If you are a new member and need to have an existing prescription refilled, remember that the prescription must be written by plan provider or it will not be covered (even if you fill it at a plan pharmacy). You should consult with your current doctor to see if he or she wants you to continue on the medication, and you must get a new prescription from your current doctor.

Using the Sample Plan mail order pharmacy service

[Explain the rules that apply to mail order drugs, using whichever parts of the model language in this subsection that are applicable, changing the wording as needed for accuracy You may add more information if you wish.]

To get order forms and information about filling your prescriptions by mail, [insert instructions]. Please note that you must use the Sample Plan mail order service. Prescription drugs that you get at any other mail order service are not covered.

[If your mail order service includes drugs other than “maintenance drugs,” substitute the following sentence for the rest of the paragraph that follows, adapting as needed for accuracy: You can use the Sample Plan mail order service to fill prescriptions for any drug that is marked as a mail-order drug on the formulary list.] You can use the mail order service to fill prescriptions for what we call [“mail order drugs” / “maintenance drugs.”]. These are drugs that you take on a regular basis, for a chronic or long-term medical condition. The formulary list tells which drugs we consider to be [mail order /maintenance]

drugs. [Add the following if applicable, adapting as needed: These are the only drugs available through our mail order service.]

[Include the following if applicable, adapting as needed for accuracy: When you order prescription drugs by mail, you must order at least a [60]-day supply, and no more than a [90]-day supply of the drug. For some [mail order/ maintenance drugs], a *refill* prescription is covered only if you get it through our mail order service (the formulary list tells you which ones).]

Things to know about getting your prescriptions filled

You may change the heading for this subsection if you wish.]

[Include this paragraph if applicable, and adapt the wording as needed for accuracy] If you fill your prescription at a pharmacy that is not a plan pharmacy, you will have to pay the full cost of the prescription yourself, and we will not pay for any part of the cost. There is an exception: prescriptions filled at a non-plan pharmacy are covered if they are related to care for a medical emergency or urgently needed care. In this situation, you can ask us to pay our share of the cost by filling out a pharmacy claim form and sending it to us within **xx** days. To get a claim form and more information, call [Insert instructions.]

[It is optional to include these first two sentences] If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. [Use whichever parts of the rest of this paragraph that apply, adapting as needed, and add further explanation as needed to tell how you handle the out of area issue.] If you plan to be away for three months or less, you may be able to order your prescription drugs ahead of time through the Sample Plan mail order pharmacy, or refill your prescriptions at a plan pharmacy away from home. To find out if there is a plan pharmacy in the area you will be visiting, call [insert instructions.] [---or---] There is no out-of-service-area benefit for prescription drugs (Section 2 tells you about our service area). Drugs you get from non-plan pharmacies while out of our service area will not be covered, regardless of the circumstances, unless they are part of care for a medical emergency or urgently needed care (care for a medical emergency and urgently needed care are discussed in Section 3).

[You may expand on the topics in the paragraphs above, or insert any additional information about filling prescriptions here, either as part of this subsection or as a new subsection, adding new headings as appropriate.]

Prescription drug benefit exclusions (drugs that are not covered)

[It is optional to add limitations to this subsection, either as a separate part or integrated into the listing of exclusions. If you add limitations, you may change the wording of the heading for this subsection as needed for accuracy.]

The following list shows which types of drugs or categories of drugs are **not** covered. These are called “exclusions.” [Adapt and expand the following sentence, as needed, so that it tells about all other places where drug exclusions are mentioned: Also, see Section 4 (Benefits chart – a list of the covered services you get as a plan member), Section 5 (“Medical care and services that are not covered – a list of exclusions”), and the formulary list for more information about drugs that are not covered.]

[Insert exclusions here.]

How to get help with questions or problems related to your prescription drug coverage

To learn more about your prescription drug benefits, call [Insert instructions here, including TTY numbers and calling hours] [optional: or visit our website at [web address]]. [If your instructions mention the name of a drug vendor, add the following sentence: [Name of drug vendor] is a company that helps handle prescription drug benefits for members of Sample Plan.]

[In the sentence that follows, if your instructions about where to call tell readers to call your drug vendor, the instructions must also tell readers where they can call at the plan (such as Member Services)]. If you have any problems or concerns related to using your prescription drug coverage, please let us know by calling [Insert instructions, including calling hours and TTY.]

From time to time, Sample, Inc. may make decisions that affect your prescription drug coverage, such as whether a particular drug is covered for you [, or whether we approve your doctor's request for an exception to the usual rules about prescription drug coverage]. If you are unhappy about a decision we make about whether a prescription is covered, or the amount of payment for a prescription, you have the right to make an appeal (an appeal asks us to reconsider and change our decision about coverage or payment). If you want to make any *other* types of complaints related to your prescription drug benefit, you would file a "grievance." Section 10 discusses grievances and appeals. You can also call Member Services to get additional information or help with a grievance or appeal.

Medicare-Approved Discount Drug Card Program

[This section is for exclusive drug card sponsors only. Exclusive drug card sponsors have the option of including language on their Medicare-approved discount drug card program in the EOC – it is not required.]

Sample, Inc. offers a Discount Drug Card Program with the Medicare-approved seal for people with Medicare. This means Medicare has approved our drug discount card program. While Medicare has approved our drug discount card, it is separate from the Medicare program and is not intended to replace any prescription drug benefits that you get with Sample Plan. [Insert the following if enrollment fees are charged] The cost of this program is [insert amount] per year.

This program is designed to help you lower the costs of your prescription drugs. As a member of the program you will be able to receive discount prices when you use your membership card at a plan pharmacy. You may also qualify for additional assistance up to \$600 from Medicare this year and again next year to be used toward the cost of your prescription drugs from plan pharmacies. This assistance is in addition to the discounts you would get through our discount drug card program.

To qualify for additional assistance up to \$600 from Medicare you will need to complete an additional form. The additional form will ask questions about your current healthcare coverage and your income level. [insert instructions on who to contact to enroll/how to enroll]

You can get more information on this program from Member Services [(call the number on the cover of this booklet)/(see Section 1 for how to contact Member Services)].

SECTION 7 Hospital care, skilled nursing facility care, and other services (this section gives additional information about some of the covered services that are listed in the Benefits Chart in Section 4)

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Hospital care

If you need hospital care, we will arrange covered services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading “Inpatient Hospital Care.” We use “hospital” to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term “hospital” does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By “custodial care,” we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

[Discuss use of plan hospitals and any other limitations such as use of hospital within the PCP’s referral network, if applicable. Also discuss use of non-plan hospitals and cost implications – you can use the language in Section 2 under “Using plan and non-plan providers to get covered services” as a guide.]

What is a “benefit period” for hospital care? [Note: This section can be deleted if the plan covers unlimited hospital days]

[Include definition/explanation of ACR approved benefit period here.]

Sample Plan uses benefit periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital). A “**benefit period**” begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF). The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. [If you offer a more generous benefit period, revise the prior sentence to reflect the plan’s benefit period] If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. (Later in this section we explain about SNF services). [Plans that use a per admission deductible – include the following sentence] In Sample Plan, a per admission deductible is applied once during a benefit period.

Please note that after your hospital day limits are used up, we will still pay for covered physician services and other medical services. These services are listed in the Benefits Chart in Section 4 under the heading, “Inpatient services (when the hospital or SNF days are not or are no longer covered).”

[Insert information about cost sharing here. For example, if the plan has an inpatient hospital deductible, include the following sentence, adapting the wording as needed for accuracy (it is optional to include the

amount of the deductible here): As shown in the Benefits Chart in Section 4, you must pay the inpatient hospital deductible for each benefit period.]

[PPO Demos that impose a penalty for unauthorized inpatient stays must include the following section]

What happens if Sample Plan did not authorize my care?

Except in cases of medical emergencies, we must give you prior authorization for your hospital stay. Explain who must get the prior authorization (i.e., the doctor or member), how the member will know that prior authorization has been granted, and the penalty for not getting prior authorization. Remind the member they have appeal rights if you impose the penalty].

What happens if you join or drop out of Sample Plan during a hospital stay?

If you either join or leave Sample Plan during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number [on the cover of this booklet / listed in Section 1]. Member Services can explain how your services are covered for this stay, and what you owe to Sample, Inc., if any, for the periods of your stay when you were and were not a plan member.

What is a “hospitalist”?

[If your plan uses physicians other than your member’s PCP or the admitting specialist to oversee care while a member is hospitalized, you should provide a complete explanation of this practice here. This includes the use of “hospitalists,” if applicable to your plan. You may modify the heading of this subsection to fit the description you provide. It is optional to include a reference to the Medicare booklet about hospitalists that is available from the Medicare website or 1-800-MEDICARE.]

Skilled nursing facility care (SNF care)

If you need skilled nursing facility care, we will arrange these services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading “Skilled nursing facility care.” The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A skilled nursing facility is a **place that provides skilled nursing or skilled rehabilitation services** [insert if appropriate to the plan benefit: to help you recover after a hospital stay]. It can be a separate facility, or part of a hospital or other health care facility. A **skilled nursing facility** is called a “SNF” for short. The term “skilled nursing facility” does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By “custodial care,” we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

[Discuss use of plan SNFs and any other limitations, if applicable]

What is skilled nursing facility care?

“Skilled nursing facility care” means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and

out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

Stays that provide custodial care only are not covered

“Custodial care” is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by Sample Plan unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are benefit period limitations on coverage of skilled nursing facility care [Note: This section can be deleted if the plan covers unlimited SNF days]

Inpatient skilled nursing facility coverage is limited to [insert number of days (usually 100, but cannot be less than 100)] days each benefit period. A “**benefit period**” begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. [If you offer a more generous benefit period, revise the prior sentence to reflect the plan’s benefit period] If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. [It is optional to add more discussion about ACR approved benefit period and cost sharing related to SNFs.]

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 4 under the heading, “Inpatient services (when the hospital or SNF days are not or are no longer covered).”

In some situations, you may be able to get care in a SNF that is not a plan provider

Generally, you will probably get your skilled nursing facility care from SNFs that are plan providers for Sample Plan. In general, if you get your SNF care from SNFs that are not plan providers, your cost sharing will be much higher. However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is not a plan provider at the same cost sharing that you would have paid if you used plan providers. One of the conditions is that the SNF that is not a plan provider must be willing to accept Sample, Inc.’s rates for payment. At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a “Home SNF”):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

[PPO Demos that impose a penalty for unauthorized SNF stays must include the following section]

What happens if Sample Plan did not authorize my care?

Except in cases of medical emergencies, we must give you prior authorization for your SNF stay.

[Explain who must get the prior authorization (i.e., the doctor or member), how the member will know that prior authorization has been granted, and the penalty for not getting prior authorization. Remind the member they have appeal rights if you impose the penalty].

What happens if you join or drop out of Sample Plan during a SNF stay?

If you either join or leave Sample Plan during a SNF stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number [on the cover of this booklet / listed in Section 1]. Member Services can explain how your services are covered for this stay, and what you owe to Sample, Inc., if any, for the periods of your stay when you were and were not a plan member.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4 under the heading “Home health care.” If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

1. You must be **home-bound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are on infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. “Supportive devices” include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

1. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The home health agency caring for you must be approved by the Medicare program.
4. **You must need at least one of the following types of skilled care:**

- Skilled nursing care on an “intermittent” (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
- Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
- Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
- Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are also getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are “part time” and “intermittent” home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for “part time” or “intermittent” skilled nursing services and home health aide services:

- **“Part-time” or “Intermittent”** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

“Hospice” is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a member of Sample Plan, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Member Services at the number [on the cover of this booklet / in Section 1] to get a list of the Medicare-certified hospice providers in your area, or you can call the Regional Home Health Intermediary at [insert number]. [Insert parenthetical if plan has Part B-only grandfathered members]: (If you are enrolled in Medicare Part B only and not entitled to Part A, you should call Member Services to get information on your hospice coverage.)

If you enroll in a Medicare-certified hospice, Original Medicare (rather than Sample Plan) pays the hospice for the hospice services you receive. Your hospice doctor can be a plan provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you are still a plan member and continue to get the rest of your care that is unrelated to your terminal condition through Sample Plan.

The Medicare program has written a booklet about “Medicare Hospice Benefits.” To get a free copy call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line, or visit the Medicare website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the website.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas (when performed with or after a Medicare-covered kidney transplant), liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A “clinical trial” is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not Sample Plan) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in Sample Plan and continue to get the rest of your care that is unrelated to the clinical trial through Sample Plan. You will have to pay the Original Medicare coinsurance for the clinical trial services. [Note: If you will cover all or a portion of the FFS coinsurance for your members participating in a clinical trial, say so here and/or modify the previous sentences. Also, specify the conditions (if any) under which such additional coverage is available (e.g., if the member participates in a clinical trial sponsored by one of your contracting providers.)]

The Medicare program has written a booklet about “Medicare and Clinical Trials.” To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web. Section 1 tells more about how to contact the Medicare program and about Medicare’s website.

You do *not* need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do *not* need to be plan providers. However, please be sure to **tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by Sample Plan under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of “nonexcepted” medical treatment. (“Excepted” medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, State or local law. “Nonexcepted” medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from Sample Plan, or your stay in the RNHCI may not be covered.

SECTION 8 What you must pay for your Medicare health plan coverage and for the care you receive

[Delete any items or parts of items in this section that are not applicable to the plan, and edit the headings and subheadings as needed for accuracy if you make any deletions.]

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Paying the plan premium for your coverage as a member of Sample Plan

[If the plan has no premium and/or no supplemental coverage with a premium, delete whatever parts of this subsection do not apply and delete or edit the main heading and subheadings as needed for accuracy. Also, you may add the word “monthly” wherever “plan premium” is used.] To be a member of Sample Plan, you must continue to pay your Medicare Part B premium. [Insert if the plan offers a Part B premium reduction] We offer a reduction in the amount that you pay for your monthly Medicare Part B premium. The amount that you will continue to pay for your Part B premium after this reduction will depend upon the total amount that you owe the Medicare program for your Part B benefits. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member. [Insert if appropriate: You also have Sample Plan premiums that you must pay.]

How much is your monthly plan premium and how do you pay it?

[You may use “method” or “program” to refer to payment plans, as shown in the model language, or you may substitute whatever name or label is used by the plan. For \$0 premium plan with optional supplemental benefits, use OPTION A for the first paragraph. If there is a plan premium, use OPTION B].

FIRST PARAGRAPH OPTION A: If you signed up for extra benefits (these are called “optional supplemental benefits”), you will have to pay a plan premium each month for these extra benefits. [Insert instructions on how to find information about the optional supplemental benefits and how much they cost].

FIRST PARAGRAPH OPTION B: **In Sample Plan, you must pay a \$___ premium each month.** [It is optional to add this sentence: This monthly plan premium covers your basic benefits.] If you signed up for extra benefits (these are called “optional supplemental benefits”), you will have to pay an additional premium each month for these extra benefits. [Insert instructions on how to find information about the optional supplemental benefits and how much they cost.]

Sample Plan offers [two] [methods / programs] for paying your monthly plan premiums. [Delete this sentence if the plan premium for basic benefits is the only premium: You can use one of these [methods /

[programs] to pay your plan premium for basic benefits and any other premiums that you may owe Sample, Inc., such as premiums for optional supplemental benefits [or for the Sample Plan Part A Equivalent Benefit Premium]. These [methods / programs] for paying your premiums are called [provide names of programs]. If you are interested in any of these [methods / programs], [insert directions for each program].

[If members should call someplace other than Member Services, replace the reference to Member Services with the name of department or place, and include the phone number and TTY number, listing hours of operation for both numbers.] If you have any questions about your plan premiums or the payment programs, please call Member Services at the number [on the cover of this booklet / in Section 1] [Add any additional specific information, such as mailing of new coupon books, timing of payments, e.g., date due, etc. If you charge for bounced checks, include this information here]

What happens if you don't pay your plan premiums, or don't pay them on time?

[Delete this subsection if the plan does not take action by downgrading or disenrolling members who fail to pay basic and optional supplemental premiums.]

[If you elect to disenroll members who fail to pay plan premiums, insert the following: If your plan premiums are past due, we will tell you in writing when a 90-day grace period begins. If you do not pay your past-due plan premiums within the 90-day grace period, we will disenroll you. Disenrolling you ends your membership in Sample, Inc. You will then have Original Medicare coverage (Section 12 explains about disenrollment and Original Medicare coverage).] [Insert if applicable to the plan: Should you decide later to re-enroll in Sample Plan, or to enroll in another plan offered by Sample, Inc., you will have to pay any past-due plan premiums that you still owe from your previous enrollment in Sample Plan.

[If you elect to discontinue offering optional supplemental benefits for members who fail to pay the premium for these benefits, insert the following: If you signed up for extra benefits ("optional supplemental benefits"), and you do not pay the additional premium for these extra benefits, we will tell you in writing when a 90-day grace period begins. If you do not pay your past-due premiums for these extra benefits within the 90-day grace period, we will no longer cover the extra benefits.]

Can your plan premiums change during the year?

We are allowed to *decrease* your plan premium at any time during the calendar year, but we are not allowed to increase it (the current calendar year is the period from January 1 through December 31, [insert year]). If we decide to decrease your plan premium during the calendar year, we will let you know in writing. **Increases in your plan premium are only allowed at the beginning of each calendar year, and must be approved by Medicare.** We will tell you in advance if there will be any changes for the next calendar year in your plan premiums or in the amounts you will have to pay when you get covered services. If there are any changes for the next calendar year, they will take effect on January 1, [insert year].

Paying your share of the cost when you get covered services

What are ["deductibles,"] "copayments" [, and "coinsurance"]?

[It is optional to include the examples with dollar amounts of copayments and coinsurance given in parentheses. If copayments and coinsurance are given in other places in addition to Section 4, add text that tells about these other places. If this subsection is about copayments only, you may delete the bullet and format the information as regular text.]

- [Include if applicable] The “**deductible**” is the amount you must pay for the health care services you receive before Sample, Inc. begins to pay its share of your covered services. [Insert information about amount and how deductible is applied (for example, if it applies to certain services only)– or-- tell readers where to find this information].
- A “**copayment**” is a payment you make for your share of the cost of certain covered services you receive. A copayment is a **set amount per service** (such as paying \$___ for [a doctor visit]). You pay it when you get the service. The Benefits Chart in Section 4 gives your copayments for covered services. [If the plan offers a prescription drug benefit with copayments, it is optional to add the following, adapting for accuracy if the information appears somewhere other than in Section 6: Section 6 gives your copayments for prescription drugs.]
- [Include if applicable] “**Coinsurance**” is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a **percentage of the cost of the service** (such as paying ___% for a [doctor visit]). You pay your coinsurance when you get the service. The Benefits Chart in Section 4 gives your coinsurance for covered services. [You may expand this bullet if necessary to provide enough information for the member to be able to calculate the amount he would owe. Also, if the plan offers a prescription drug benefit with coinsurance, it is optional to add the following, adapting for accuracy if the information appears somewhere other than in Section 6: Section 6 gives your coinsurance for prescription drugs.]

[Include if applicable] **What is the most you will pay for covered care?**

There is a limit to how much you will have to pay for your covered health care each year. During the year, if the amount that you spend on your [deductible,] copayments, [and coinsurance] as a member of Sample Plan goes over \$[insert annual out-of-pocket maximum amount], we will begin to pay for all of your covered health care.

You must pay the full cost of services that are not covered

You are personally responsible to pay for care and services that are not covered by Sample Plan. Other sections of this booklet tell about covered services and the rules that apply to getting your care as a plan member.

[If there is no prescription drug benefit, or no limit on prescription drug coverage, delete the references to prescription drugs in the last sentence and replace this example of prescription drugs with a different example of a benefit that has a limitation.] For covered services that have a benefit limitation, **you must pay the full cost of any services you get after you have used up your benefit for that type of covered service.** [Insert example, such as: For example, you have to pay the full cost of any prescription drugs you get after Sample Plan’s payments for your prescriptions reach the [quarterly/yearly] benefit limit.] [Explain whether paying for costs once a benefit limit has been reached will count towards an out-of-pocket maximum.] You can call Members Services when you want to know how much of your benefit limit you have already used.

You may pay more to see non-plan providers

Your out-of-pocket costs may be higher if you use non-plan providers than if you use plan providers. We will pay for covered care that you get from non-plan providers. However, you may pay more for that care if it was not emergency care because non-plan providers do not have agreements with us to accept a certain amount as payment in full for your care. As a result, you will have to pay any difference between the amount the non-plan provider charges and the amount we pay (up to the Medicare limiting charge), in addition to any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services.

You will pay less to see our plan providers because these providers have agreed to accept a specific negotiated amount as payment in full for services provided to you. There are a lot of doctors, hospitals, and other health care providers who are Sample Plan providers. If you do not have a list of our plan providers (called the “Provider Directory”) and would like to have one, please call Member Services at the telephone number [\[on the cover of this booklet / listed in Section 1\]](#).

Please keep us up-to-date on any other health insurance coverage you have

Using all of your insurance coverage

If you have other health insurance coverage besides Sample Plan, it is important to use this other coverage *in combination with* your coverage as a member to pay for the care you receive. This is called “coordination of benefits” because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage besides Sample Plan, and let us know whenever there are any *changes* in your additional insurance coverage. The types of additional insurance you might have include the following:

- Coverage that you have from an employer’s group health insurance for *employees* or *retirees*, either through yourself or your spouse.
- Coverage that you have under workers’ compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the “Tricare for Life” program (veteran’s benefits).
- Coverage you have for dental insurance or prescription drugs.
- “Continuation coverage” that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

Who pays first when you have additional insurance?

When you have additional insurance coverage, how we coordinate your benefits as a member of Sample Plan with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through Sample Plan, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by Sample Plan, you may get your care outside of Sample Plan.

In general, the insurance company that pays its share of your bills *first* is called the “**primary payer.**” Then the other company or companies that are involved -- called the “**secondary payers**” -- each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second --or at all-- depends on what type or types of additional insurance you have and the rules that apply to your situation.** Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer’s group insurance.

If you have additional health insurance, please call Member Services at the phone number on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It’s called *Medicare and Other Health Benefits: Your Guide to Who Pays First*. You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or by visiting the www.medicare.gov website.

What should you do if you have bills from non-plan providers that you think we should pay?

If a non-plan provider asks you to pay for covered services, please contact us at [insert instructions that include a mailing address]. It is best to ask a non-plan provider to bill us first, but if you have already paid for the covered services we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. A non-plan provider will not be paid any more than what he or she would have received if you had been covered with Original Medicare.

Section 9 Your rights and responsibilities as a member of Sample Plan

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Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 9, we explain your Medicare rights and protections as a member of Sample Plan. Then, after we have explained your rights, we tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048).

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. Sample, Inc. must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you need help with communication, such as help from a language interpreter, please call Member Services at the number [\[on the cover of this booklet / shown in Section 1\]](#). Member Services can also help if you need to file a complaint about access (such as wheel chair access).

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your

health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask [us/plan providers] to make additions or corrections to your medical records (if you ask [us/plan providers] to do this, [we/they] will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services at the phone number [on the cover of this booklet / in Section 1].

Your right to see plan and non-plan providers and get covered services within a reasonable period of time

As explained in this booklet, you can get most or all of your care from plan providers, that is, from doctors and other health providers who are part of Sample Plan. You can also get most or all of your care from non-plan providers, that is, from doctors and other health providers who are not part of Sample Plan [PPOs that do not require any referrals or prior authorization should delete the next two sentences and instead state “You have the right to choose a provider for your care.”] You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to go to a women’s health specialist (such as a gynecologist) without a referral or prior authorization. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. “Timely access” means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by Sample Plan. 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, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a plan provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. “Initial decisions” are discussed in Sections 10 and 11.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical

facility, even if your doctor advises you not to leave. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called “**advance directives.**” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. [You can list your organization as a contact if they provide these forms]. [If the EOC is for a single state, replace the mentions of “SHIP” with the actual name of the SHIP in that state in the sentences that follow.] You can sometimes get advance directive forms from organizations that give people information about Medicare, such as [state-specific name of SHIP] / your SHIP (which stands for **State Health Insurance Assistance Program**). Section 1 of this booklet tells how to contact [{state-specific name of SHIP} / your SHIP]. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with [List appropriate state-specific agency here, such as State Department of Health. Provide contact information].

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. “Appeals” and “grievances” are the two different types of complaints you can make. Which one you make depends on your situation. Appeals are discussed in Sections 10 and 11, and grievances are discussed in Section 10.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed *against* Sample, Inc. in the past. To get this information, call Member Services at the phone number [on the cover of this booklet/shown in Section 1].

Your right to get information about your health care coverage and costs

This booklet [Add a reference here to other additional materials such as member handbooks or inserts, if applicable] tells you what medical services are covered for you as a plan member and what you have to pay. If you need more information, please call Member Services at the number [on the cover of this booklet/shown in Section 1]. You have the right to an explanation from us about any bills you may get for services not covered by Sample Plan. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 10 and 11 for more information about filing an appeal.

Your right to get information about Sample, Inc., Sample Plan, and plan providers

You have the right to get information from us about Sample, Inc., and Sample Plan. This includes information about our financial condition, about our health care providers and their qualifications, and about how Sample Plan compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Services at the phone number [on the cover of this booklet/shown in Section 1].

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Member Services at the number [on the cover of this booklet / shown in Section 1]. You can also get free help and information from [{state-specific name of SHIP} / your State Health Insurance Assistance Program, or SHIP] (Section 1 tells how to contact [{state-specific name of SHIP / the SHIP in your state}]). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections*. To get a free copy, call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). Or you can visit the Medicare website at www.medicare.gov to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights in your area at [insert phone numbers for the Office of Civil Rights in all applicable states or regions].
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Member Services at the number [on the cover of this

booklet/shown in Section 1]. You can also get help from [state-specific name of SHIP] / your State Health Insurance Assistance Program, or SHIP] (Section 1 tells how to contact [state-specific name of SHIP / the SHIP in your state]).

What are your responsibilities as a member of Sample Plan?

Along with the rights you have as a member of Sample Plan, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you [insert specifics about other information if applicable] to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services at the phone number [on the cover of this booklet/shown in Section 1] if you have any questions.
- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To pay your plan premiums and any copayments you may owe for the covered services you get. You must also meet your other financial responsibilities that are described in Section 8 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone number [on the cover of this booklet/shown in Section 1].

SECTION 10 Appeals and grievances: what to do if you have complaints

[If this EOC is for a single state, replace the references to the QIO with the actual name of the QIO in that state throughout this section, adapting any wording as needed to accommodate this substitution.]

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Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your covered services or the care you receive. Please call Member Services at the number [on the cover of this booklet / listed in Section 1].

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from Sample Plan or penalized in any way if you make a complaint.

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. “Appeals” and “grievances” are the two different types of complaints you can make.

- An **“appeal”** is the type of complaint you make **when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service.** For example, if we refuse to cover or pay for services you think we should cover, you can file an appeal. If Sample, Inc. or one of our plan providers refuses to give you a service you think should be covered, you can file an appeal. If Sample, Inc. or one of our plan providers reduces or cuts back on services you have been receiving, you can file an appeal. If you think we are stopping your coverage of a service too soon, you can file an appeal.
- A **“grievance”** is the type of complaint you make **if you have any other type of problem with Sample Plan or one of our plan providers.** For example, you would file a grievance if you have

a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

This section tells how to make complaints in different situations

The rest of this section has separate parts that tell you how to make a complaint in each of the following situations:

- 1. Making complaints (called “appeals”) about what we will cover for you or what we will pay for.** If Sample, Inc. or your doctor or another plan provider has refused to give you a service you think is covered, you can make an appeal. If we have refused to pay for a service you think is covered for you, you can make an appeal. If you have been receiving a covered service, and you think that service is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay).
- 2. Making complaints (called “appeals”) if you think you are being discharged from the hospital too soon.** There is a special type of appeal that applies only to hospital discharges. If you think our coverage of your hospital stay is ending too soon, you can appeal directly and immediately to [state-specific name of the QIO], which is the Quality Improvement Organization in the state of {name of state} / the QIO. [State-specific name of QIO] / The QIO is a group of health professionals [in your state] that is paid to handle this type of appeal from Medicare patients. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.
- 3. Making complaints (called “appeals”) if you think your coverage for SNF, home health or comprehensive outpatient rehabilitation facility services is ending too soon.** There is another special type of appeal that applies only to when coverage will end for SNF, home health or comprehensive outpatient rehabilitation facility services. If you think your coverage is ending too soon, you can appeal directly and immediately to [state-specific name of the QIO], which is the Quality Improvement Organization in the state of {name of state} / the QIO. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

[Note that the text substitutions of “{state-specific name of the QIO}” for “The Quality Improvement Organization” are no longer marked for you in the remainder of this section (you should still make them, if the EOC is for a single state).

- 4. Making complaints (called “grievances”) about any other type of problem you have with Sample Plan or one of our plan providers.** If you want to make a complaint about any type of problem other than those that are listed above, a grievance is the type of complaint you would make. For example, you would file a grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office. Generally, you would file the grievance with Sample, Inc. But for many problems related to quality of care you get from plan providers, you can also complain to the QIO in your state.

PART 1. Making complaints (called “appeals”) to Sample, Inc. to change a decision about what we will cover for you or what we will pay for

This part of Section 10 explains what you can do if you have problems getting the medical care you believe we should provide. We use the word “provide” in a general way to include such things as authorizing care, paying for care, arranging for someone to provide care, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by Sample Plan.
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by Sample Plan.
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe was covered by Sample Plan while you were a member, but we have refused to pay for this care.

Six possible steps for requesting care or payment from Sample Plan

If you are having a problem getting care or payment for care, there are six possible steps you can take to ask for the care or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, there may be another step you can take if you want to continue requesting the care or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The six possible steps are summarized below (they are covered in more detail in Section 11).

STEP 1: The initial decision by Sample, Inc.

The starting point is when we make an “initial decision” (also called an “organization determination”) about your medical care or about paying for care you have already received. When we make an “initial decision,” we are giving our interpretation of how the benefits and services that are covered for members of Sample Plan apply to your specific situation. As explained in Section 11, you can ask for a “fast initial decision” if you have a request for medical care that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by Sample, Inc.

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an “**appeal**” or a “request for reconsideration.” As explained in Section 11, you can ask for a “fast appeal” if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change

this decision and give you some or all of the care or payment you want.

STEP 3: Review of your request by an Independent Review Organization

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of Sample, Inc. This organization will review your request and make a decision about whether we must give you the care or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least \$100 to be considered in Step 4.

STEP 5: Review by a Medicare Appeals Council

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask a **Medicare Appeals Council** to review your case. This Council is part of the federal department that runs the Medicare program.

STEP 6: Federal Court

If you or we are unhappy with the decision made by the Medicare Appeals Council in Step 5, either of us may be able to take your case to a Federal Court. The dollar value of your contested medical care must be at least \$1,050 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, see Section 11.

PART 2. Making complaints if you think you are being discharged from the hospital too soon

When you are hospitalized, you have the right to get all the hospital care covered by Sample Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your “discharge date”) is based on when your stay in the hospital is no longer medically necessary. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.

- Your right to appeal a discharge decision.

Review of your hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, you must ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights*. This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not receive the notice when you are being told about your discharge from the hospital, be sure to ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the “Quality Improvement Organization”?

[If EOC is for a single state, adapt this subsection to use the actual name of the QIO] “QIO” stands for **Quality Improvement Organization**. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of Sample, Inc. or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. [In {name of state}, the QIO is called {name of QIO}]. The doctors and other health experts in [{name of QIO}/the QIO] review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the QIO.

Getting a QIO review of your hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the QIO. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for a “**fast review**” of whether you are ready to leave the hospital. This “fast review” is also called a “fast appeal” because you are appealing the discharge date that has been set for you.
- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from

the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the calendar day after the QIO gives you its decision.
- If the QIO agrees with you, then we will continue to cover your hospital stay for as long as medically necessary.

What if you do not ask the QIO for a review by the deadline?

You still have another option: asking Sample, Inc. for a “fast appeal” of your discharge

If you do not ask the QIO for a “fast review” (“fast appeal”) of your discharge by the deadline, you can ask us for a “fast appeal” of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you run the risk of having to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as medically necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, then we will **not** cover any hospital care you received if you stayed in the hospital after the discharge date.

You may have to pay if you stay past your discharge date

If you stay in the hospital after your discharge date and do not ask for immediate QIO review, you may be financially responsible for the cost of many of the services you receive. However, you can appeal any bills for hospital care you receive, using Step 1 of the appeals process described in Section 11.

PART 3. Making complaints (appeals) if you think your coverage for SNF, home health or comprehensive outpatient rehabilitation facility services is ending too soon.

When you are a patient in a SNF, home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by Sample Plan that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA or CORF coverage is based on when your stay is no longer medically necessary. This part of Section 10 explains what to do if you believe that your coverage is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

If we decide to end our coverage for your SNF, HHA, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or someone you authorize) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

How to appeal the termination of your coverage to the Quality Improvement Organization

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us your provider, you can ask the Quality Improvement Organization (the “QIO”) to do an independent review of whether our terminating your coverage is medically appropriate.

How soon do you have to ask the QIO to review your coverage?

If you want to have the termination of your coverage appealed, you must act quickly to contact the QIO. The written notice you got from us or your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must be sure to make your request **no later than noon** of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, then you must make your request **no later than noon** the day before the date that your Medicare coverage ends.

What will happen during the review?

If the QIO reviews your case, the QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why your services should not continue.

After reviewing all the information, the QIO will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in your favor?

If the QIO agrees with you, then we will continue to cover your SNF, HHA or CORF services for as long as medically necessary.

What happens if the QIO denies your request? If the QIO decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor Sample, Inc. will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

What if you do not ask the QIO for a review in time?

You still have another option: asking Sample, Inc. for a “fast appeal” of your discharge

If you do not ask the QIO for a “fast appeal” of your discharge by the deadline, you can ask us for a “fast appeal” of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you run the risk of having to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting coverage for your care, then we will **not** cover any care you received if you stayed after the termination date.

You may have to pay if you stay past your discharge date

If you do not ask the QIO to review your coverage termination by noon of the day before termination of your SNF, HHA or CORF services, and if you stay in the SNF or continue receiving HHA or CORF services after the termination date, you run the risk of having to pay for the care you receive after this date. However, you can appeal any bills for SNF, HHA or CORF care you receive using Step 1 of the appeals process described in Section 11.

PART 4. Making complaints (called “grievances”) about any other type of problem you have with Sample Plan or one of our plan providers

This last part of Section 10 explains how to make complaints about any *other* type of problem that has not already been discussed earlier in this section. (The problems that have already been discussed are problems related to coverage or payment for care, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending too soon.)

What is included in “all other types of problems”?

Here are some examples of problems that are included in this category of “all other types of problems”:

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) Sample Plan.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor’s offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called “filing a

grievance.” In addition, you have the right to ask for a “fast grievance” if you disagree with our decision to not give you a “fast appeal” or if we take an extension on our initial decision or appeal. See below for more detail.

Filing a grievance with Sample Plan

If you have a complaint, we encourage you to first call Member Services at the number [on the cover of this booklet/shown in Section 1]. We will try to resolve any complaint that you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this [insert name of your grievance procedure, then insert description of the procedures (including time frames) and instructions about what members need to do if they want to use it. Be sure to describe expedited grievance timeframes for grievances about decisions to not conduct expedited organizational determinations or reconsiderations or to take extensions on initial decisions or appeals].

For quality of care problems, you may also complain to the QIO

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to an independent organization called the QIO. See Section 1 for more information about the QIO.

SECTION 11 Detailed information about how to make an appeal

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What is the purpose of this section?

The purpose of this section is to give you more information about a topic that is summarized briefly in the previous section of this booklet (Section 10). Section 10 outlines the six possible steps in the appeals process for making complaints about your coverage or payment for your care. This section goes through the same six steps in more detail. Since Section 10 also gives general information about making complaints, and discusses how to deal with other types of problems besides problems with coverage or payment for care, **you should read Section 10 before you read this section.**

A note about terminology. In this Section, we tend to use simpler language instead of certain legal language, including terms that appear in the government regulations for the appeals process. For example, we generally say “initial decision” instead of “initial organization determination,” and we generally use the word “fast” rather than “expedited” when referring to decisions that are made more quickly than the standard time frame. Instead of saying “adverse decision,” we may say “deny your request,” or “turn down your appeal.” We use “independent review organization” rather than “independent review entity.”

What are “complaints about your coverage or payment for your care”?

Complaints about your coverage or payment for your care are complaints you may have if you are not getting medical benefits and services you believe are covered for you as a plan member. This includes payment for care received while a member of the Sample Plan. Complaints about your coverage or payment for your care include complaints about the following situations:

- If you are not getting the care you want, and you believe that this care is covered by Sample Plan
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by Sample Plan
- If you are being told that coverage for a treatment or service you have been getting will be

reduced or stopped, and you feel that this could harm your health

- If you have received care that you believe is covered by Sample Plan, but we have refused to pay for this care because we say it is not covered

How does the appeals process work?

The six possible steps you can take to make complaints related to your coverage or payment for your care are described below. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one step to the next.** At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the medical care involved or on other factors.
- **“Initial decision” vs. “making an appeal.”** Step 1 deals with the starting point for the appeals process. The decision made in Step 1 is called an “initial decision” or “organization determination.” If you continue with your complaint by going on to Step 2, it is called making an “appeal” or a “request for reconsideration” of our initial decision because you are “appealing” for a change in the initial decision that was made in Step 1. Step 2, and all of the remaining possible steps, also involve *appealing* a decision.
- **Who makes the decision at each step.** In Step 1, you make your request for coverage of care or payment for care directly to us. We review this request, then make an initial decision. If our initial decision turns down your request, you can go on to Step 2, where you “appeal” this initial decision (asking us to reconsider). **After Step 2, your appeal goes outside of Sample, Inc., where people who are not connected to us conduct the review and make the decision.** To help ensure a fair, impartial decision, those who make the decision about your appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

STEP 1: Sample, Inc. makes an “initial decision” about your medical care, or about paying for care you have already received

What is an “initial decision”?

The “initial decision” made by Sample, Inc. is the starting point for dealing with requests you may have about your coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received. (This “initial decision” is sometimes called an “organization determination.”) If our initial decision is to deny your request (this is sometimes called an “adverse initial decision”), you can “appeal” the decision by going on to Step 2 (see below). You may also go on to Step 2 if we fail to make a timely “initial decision” on your request.

- If you ask us to pay for medical care you have already received, this is a request for an “initial decision” about payment for your care. You can call us at [phone number] to get help in making

this request.

- If you ask for a specific type of medical treatment from your doctor or other medical provider, this is a request for an “initial decision” about whether the treatment you want is covered by Sample Plan. Depending on the situation, your doctor or other medical provider may make this decision on behalf of Sample, Inc., or may ask us whether we will authorize the treatment. You may want to ask us for an initial decision without involving your doctor. You can call us at [phone number] to ask for an initial decision.

When we make an “initial decision,” we are giving our interpretation of how the benefits and services that are covered for members of Sample Plan apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by Sample Plan, including any limitations that may apply to these services. This booklet also lists exclusions (services that are “not covered” by Sample Plan).

Who may ask for an “initial decision” about your medical care or payment?

You can ask us for an initial decision yourself, or you can name someone to do it for you. This person you name would be your *authorized representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your authorized representative. This statement must be sent to us at [address]. You can call us at [insert number and TTY number] to learn how to name your authorized representative.

You also have the right to have an attorney ask for an initial decision on your behalf. 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. You may want to contact [Legal Agency Name] at [phone number, and TTY # if one is available].

“Standard decisions” vs. “fast decisions” about medical care

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days; see below), or it can be a “fast decision” that is made more quickly (typically within 72 hours; see below). A fast decision is sometimes called a 72-hour decision or an “expedited organization determination.”

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address: Sample, Inc., [address].

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a “fast” decision (rather than a

“standard” decision) about medical care by calling us at [phone number] (for TTY, call [phone number]). Or, you can deliver a written request to Sample, Inc., [address], or fax it to [fax number]. [Specify instructions for delivering requests that are made outside of regular weekday business hours] Be sure to ask for a “fast” or “72-hour” review.

- If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor’s support for a “fast” review, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a “fast grievance.” If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 14 calendar days; see below).

What happens when you request an “initial decision”?

What happens, including how soon we must decide, depends on the type of decision.

1. *For a decision about payment for care you already received.*

We have 30 calendar days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 calendar days of your request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then appeal this decision. (An appeal is also called a reconsideration.) Step 2 tells how to file this appeal.

2. *For a standard initial decision about medical care.*

We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request the additional time, or if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a “grievance.” Section 10 of this booklet tells how to file a grievance.

We will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Step 2 tells how to file this appeal.

If you have not received an answer from us within 14 calendar days of your request for the initial decision, the failure to receive an answer is the same as being told that your request was not approved, and you have the right to appeal. Step 2 tells how to file this appeal. If we tell you that we extended the

number of days needed for a decision and you have not received an answer from us by the end of the extension period, the failure to receive an answer is the same as being told that your request was not approved, and you do have the right to appeal.

3. For a fast initial decision about medical care.

If you receive a “fast” review, we will give you our decision about your medical care within 72 hours after you or your doctor ask for a “fast” review -- sooner if your health requires. However, we are allowed to take up to 14 more calendar days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you can make a specific type of complaint called a “grievance.” Section 10 of this booklet tells how to file a grievance.

We will tell you our decision by phone as soon as we make the decision. Within three calendar days after we tell you of our decision in person or by phone, we will send you a letter that explains the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If we deny your request for a fast decision, you may file a grievance. Section 10 of this booklet tells how to file a grievance.

What happens next if we decide completely in your favor?

If we make an “initial decision” that is completely in your favor, what happens next depends on the situation.

1. For a decision about payment for care you already received.

We must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.

2. For a standard decision about medical care.

We must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received the request you made for the initial decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision.

3. For a fast decision about medical care.

We must authorize or provide you with the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must provide it sooner.

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for care that you have already received, we may say that we will pay nothing or only part of the amount you requested. In denying a request for medical care, we might decide not to approve any of the care you want, or only some of the care you want. If any initial decision does not give you *all* that you requested, you have the right to ask us to reconsider the decision. (See Step 2).

STEP 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an “appeal” or “request for reconsideration.”

Please call us at [insert number] if you need help in filing your appeal. You may ask us to reconsider the initial decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a “fast” appeal. The procedures for deciding on a “standard” or a “fast” *appeal* are the same as those described for a “standard” or “fast” *initial decision* in Step 1. Please see the discussion in Step 1 under “Do you have a request for medical care that needs to be decided more quickly than the standard time frame?” and “Asking for a fast decision.” [If you have your appeals sent to a different office than organization determinations, you should mention that while the process for deciding on a standard or fast appeal are the same as in Step 1, the place where the appeal is sent is different – refer them to “What if you want a ‘fast’ appeal” later in this section for more information.]

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor’s records or the doctor’s opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to Sample, Inc., [insert address].
- By fax, at [insert number].
- By telephone -- if it is a “fast” appeal – at 1-800-555-5555.
- In person, at [insert street address].

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-800-555-5555, Sample, Inc., [insert address]. [if a fee is charged, insert: We are allowed to charge a fee for copying and sending this information to you.]

How do you file your appeal of the initial decision?

The rules about who may file an appeal in Step 2 are the same as the rules about who may ask for an “initial decision” in Step 1. Follow the instructions in Step 1 under “Who may ask for an ‘initial decision’” about medical care or payment?”

Either you, someone you appoint, or your provider may file this appeal.

However, providers who do not have a contract with Sample, Inc. must sign a “waiver of payment” statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

The appeal should be given to us in writing at Sample, Inc., [insert address], within 60 calendar days

after we notify you of the initial decision from Step 1. We can give you more time if you have a good reason for missing the deadline.

You may also send your appeal to your Social Security Administration office. Please note that sending your appeal to this office instead of to us will cause a delay when we begin the appeal, since this office must forward your appeal request to us.

What if you want a “fast” appeal?

The rules about asking for a “fast” appeal in Step 2 are the same as the rules about asking for a “fast” initial decision in Step 1. If you want to ask for a “fast” appeal in Step 2, please follow the instructions in Step 1 under “Asking for a fast decision.” [If you have appeals sent to a different office than organization determinations, you should mention that while the process for deciding on a standard or fast appeal are the same as in Step 1, the place where the appeal is sent is different; also include instructions for where to send appeal requests.]

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a decision about payment for care you already received.*

After we receive your appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your appeal *automatically* goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

After we receive your appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30 calendar days (or by the end of the extended time period), your request will *automatically* go to Step 3, where an independent organization will review your case.

3. *For a fast decision about medical care.*

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will *automatically* go to Step 3, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about payment for care you already received.*

We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision. If we decide only partially in your favor, your appeal *automatically* goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

We must authorize or provide you with the care you have asked for as quickly as your health requires, but no later than 30 calendar days after we received your appeal. If we extend the time

needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

3. *For a fast decision about medical care.*

We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal -- or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your appeal?

If we deny any part of your appeal in Step 2, then your appeal *automatically* goes on to Step 3 where an independent organization will review your case. This independent review organization contracts with the federal government and is not part of Sample, Inc. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the independent review organization that performs the review in Step 3 depends on the type of appeal:

1. *For a decision about payment for care you already received.*

We must send all the information about your appeal to the independent review organization within 60 calendar days from the date we received your appeal in Step 2.

2. *For a standard decision about medical care.*

We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your appeal in Step 2.

3. *For a fast decision about medical care.*

We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

STEP 3: If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization

What independent review organization does this review?

In Step 3, your appeal is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization. [Insert if you charge a fee: We are allowed to charge you a fee for copying and sending this information to you.]

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. *For an appeal about payment for care, the independent review organization has up to 60 calendar*

days to make a decision.

2. For a standard appeal about medical care, the independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.
3. For a fast appeal about medical care, the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. For an appeal about payment for care,

We must pay within 30 calendar days after receiving the decision.

2. For a standard appeal about medical care,

We must *authorize* the care you have asked for within 72 hours after receiving notice of the decision from the independent review organization, or *provide* the care as quickly as your health requires, but no later than 14 calendar days after receiving the decision.

3. For a fast appeal about medical care,

We must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You may continue your appeal by asking for a review by an Administrative Law Judge (see Step 4), provided that the dollar value of the medical care or the payment in your appeal is \$100 or more.

You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date you were notified of the decision made in Step 3. You can extend this deadline for good cause. You have a choice about where you send your written request:

- Directly to the independent review organization that reviewed your appeal in Step 3. They will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.
- To Sample, Inc., or to your local Social Security Administration office. If you do this, starting Step 4 will take longer because your request must first be forwarded to the independent review organization that reviewed your appeal in Step 3. The independent review organization will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.

STEP 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an

Administrative Law Judge

As stated in Step 3, if the independent review organization does not rule completely in your favor, you may ask them to forward your appeal for a review by an Administrative Law Judge. During this review, you may present evidence, review the record, and be represented by counsel. The Administrative Law Judge will not review the appeal if the dollar value of the medical care is less than \$100. If the dollar value is less than \$100, you may not appeal any further.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 calendar days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5). The letter you get from the Administrative Law Judge will tell you how to request this review.

STEP 5: Your case may be reviewed by a Medicare Appeals Council

This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then either you or Sample, Inc. may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is \$1,050 or more. If the dollar value is less than \$1,050, you may not appeal any further.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least \$1,050. If the dollar value is less than \$1,050, the Council's decision is final.

If the Council decides against you

If the amount involved is \$1,050 or more, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than \$1,050, the Council's decision is final and you may not take the appeal any further.

STEP 6: Your case may go to a Federal Court

If the contested amount is \$1,050 or more, you or we may ask a Federal Court Judge to review the case.

SECTION 12 Leaving Sample Plan and your choices for continuing Medicare after you leave

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What is “disenrollment”?

“Disenrollment” from Sample Plan means **ending your membership** in Sample Plan. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave Sample Plan because you have decided that you *want* to leave. You can do this for any reason.
- There are also a few situations where you would be *required* to leave. For example, you would have to leave Sample Plan if you move out of our geographic service area or if Sample Plan leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving the plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

Until your membership officially ends, you should keep getting your Medicare services through Sample Plan or you will have to pay more for your services

If you leave Sample Plan, it takes some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and should continue to get your care as usual through Sample Plan.

What are your choices for continuing Medicare if you leave Sample Plan?

If you leave Sample Plan, one choice for continuing with Medicare is to go to **Original Medicare**. You

may also have the choice of joining another **Medicare managed care plan** or a **Medicare Private Fee-for-Service plan** if any of these types of plans are available in your area and they are accepting new members.

- **Original Medicare** is available throughout the country. It is a pay-per-visit or “fee-for-service” health plan that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay a deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
- **Medicare Managed Care Plans** (such as HMOs or PPOs) are available in some parts of the country. In HMOs you go to the doctors, hospitals, and other providers *that are part of the plan*. In PPOs, you can usually see any doctor but you may pay more to see doctors, hospitals, and other providers that are *not* part of the plan. These plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescriptions drugs. [Insert if applicable: Sample Plan is a Medicare managed care plan offered by Sample, Inc.].
- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to *any* Medicare-approved doctor or hospital that accepts the plan’s payment. The Private Fee-for-Service plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover. Private Fee-for-Service plans are *not* the same as Medigap (Medicare supplement insurance) policies. [Insert if applicable: Sample Plan is a Medicare Private Fee-for-Service plan offered by Sample, Inc.].

When can you change your Medicare choices?

All through the year, everyone with Medicare (including members of Sample Plan) is allowed to change from their current way of getting Medicare to one of their other choices. As we have explained above, you have one or more of the following choices about how you get your Medicare coverage. They are:

- **Original Medicare.** This choice is available to you throughout the year.
- **A Medicare Managed Care Plan.** This choice is available to you **if** there are Medicare managed care plans in your area, and **if** they are accepting new members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare Advantage plans must accept new members (unless unusual circumstances apply). (Medicare Advantage is the new name for Medicare + Choice).
- **A Medicare Private Fee-for-Service plan.** This choice is available to you **if** there are Medicare Private Fee-for-Service plans in your area, and **if** they are accepting new members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare Private Fee-for-Service plans must accept new members (unless unusual circumstances apply).

In most cases, your disenrollment date will be the first day of the month that comes *after* the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. There is an exception: if we receive your request

between November 15 and 30, the change will take effect on January 1, unless you specifically ask for a disenrollment date of December 1.

What should you do if you decide to leave Sample Plan?

If you want to leave Sample Plan, what you must do to leave depends on whether you want to change to Original Medicare or to one of your other choices.

How to change from Sample Plan to Original Medicare

Do you need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from Sample Plan to Original Medicare, you should think about whether you need to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact [{{state-specific name of SHIP}}/the SHIP in your state] (the phone number is in Section 1). You can ask [{{state-specific name of SHIP}}/the SHIP] about how and when to buy a Medigap policy if you need one. [{{State-specific name of SHIP}}/The SHIP] can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you have a “**guaranteed issue right**,” this means that the Medigap insurer must sell you a Medigap policy, even if you have health problems. This is a special, temporary right, which means that if you decide to change to Original Medicare you have a limited time to buy a Medigap policy on a guaranteed issue basis. For example, you have a guaranteed issue right to buy a Medigap policy if you are in a Medicare managed care plan “trial period” and you change to Original Medicare. Generally, a Medicare managed care plan trial period begins on the date of “first time” enrollment in a Medicare health plan (other than Original Medicare) and ends 12 months later. You may be in a Medicare managed care plan trial period if in the past 12 months you: (1) dropped a Medigap policy to join a Medicare health plan for the first time; or (2) joined a Medicare health plan upon first becoming entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. [{{State-specific name of SHIP}}/The SHIP] can tell you about other situations where you may have guaranteed issue rights.

If you do buy a Medigap policy, you still have to follow the instructions below for changing from Sample Plan to Original Medicare. (Buying a Medigap policy does not switch you from Sample Plan to Original Medicare. A Medigap sales person or insurance agent cannot cancel your Sample Plan membership and put you in Original Medicare.)

How to change from Sample Plan to Original Medicare

If you decide to change from Sample Plan to Original Medicare, you must tell us (or one of the offices listed below) that you want to leave Sample Plan. You do *not* have to notify Original Medicare, because you will automatically be in Original Medicare when you leave Sample Plan. Here is how it works:

1. First, use any of the following ways to tell us that you want to leave Sample Plan:
 - You can write or fax a letter to us [Mentioning the disenrollment form is optional] or fill out a disenrollment form and send it to Member Services at [address] or to our fax number at [fax number]. Be sure to sign and date your letter [form]. To get a disenrollment form, call us at [insert phone number or if applicable say: the Member Services telephone number [on the cover of this booklet/shown in Section 1].]

- You can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048.
 - You can contact your nearest Social Security office or, if you have Railroad Retirement benefits, you can contact the Railroad Retirement Board office. Section 1 tells you how to contact these offices.
2. We will then send you a letter that tells you when your membership will end. This is your **disenrollment date** – the day you officially leave Sample Plan. In most cases, your disenrollment date will be the first day of the month that comes after the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. There is an exception: the disenrollment date for requests received between November 15 and November 30 are effective on January 1, unless you specifically ask us to disenroll you on December 1. Remember, while you are waiting for your membership to end, you are still a member of Sample Plan and should continue to get your medical care as usual through Sample Plan.
 3. On your disenrollment date, your membership in Sample Plan ends, and you can start using your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave Sample Plan. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

How to change from Sample Plan to [a/another] Medicare managed care plan or to [a/another] Private Fee-for-Service Plan

If you want to change from Sample Plan to a [different] Medicare managed care plan or to a [different] Private Fee-for-Service plan, here is what to do:

1. Contact the plan you want to join to be sure it is accepting new members.
2. If the plan is accepting new members, apply for membership in the plan. **Once you are enrolled in your new plan, your membership in Sample Plan will automatically end.** This means that you do not need to tell us that you are leaving. However, we do encourage you to tell us why you left.
3. Your new plan will tell you in writing the date when your membership in that plan begins, and your membership in Sample Plan will end on that same day (this will be your “disenrollment date”). Remember, you are still a member until your disenrollment date, and should continue to get your medical care as usual through Sample Plan until the date your membership ends.

What happens to you if Sample, Inc. leaves the Medicare program or Sample Plan leaves the area where you live?

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in Sample Plan will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through Sample Plan until your membership ends.

Your choices will always include Original Medicare. Your choices may also include joining [insert if appropriate: [a/another] Sample, Inc. plan], [a/ another] Medicare managed care plan, or [a / another] Private Fee-for-Service plan, if these plans are available in your area and are accepting new members.

Once we have told you in writing that we are leaving the Medicare program or the area where you live, you may change to another way of getting your Medicare benefits at any time. If you decide to change from Sample Plan to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a “guaranteed issue right” and it is explained earlier in this section under the heading, “Do you need to buy a Medigap (Medicare supplement insurance) policy?”

Sample, Inc. has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either Sample, Inc. or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time, too. If the contract is going to end, we will generally tell you 90 days in advance. Your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

You must leave Sample Plan if you move out of the service area or are away from the service area for more than six months in a row

If you plan to move or take a long trip, please call Member Services at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in plan’s service area. If you move permanently out of our service area, or if you are away from our service area for more than six months in a row. [If you currently offer a visitor/traveler benefit, insert proper time frame], you will need to leave (“disenroll” from) Sample Plan. In these situations, if you do not leave on your own, we must end your membership (“disenroll” you). An earlier part of this section tells about the choices you have if you leave Sample Plan and explains how to leave. [PPOs with visitor/traveler benefits add the following sentence] Section 2 gives more information about getting care when you are away from the service area.

Under certain conditions Sample, Inc. can end your membership and make you leave the plan

We *cannot* ask you to leave the plan because of your health

No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave Sample Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line.

We can ask you to leave the plan under certain special conditions

If any of the following situations occur, we will need to end your membership in Sample, Inc.

- If you move out of our geographic service area or live outside the plan’s service area for more than six months at a time [If you currently offer a visitor/traveler benefit, insert proper time frame] (see Section 2 for information about the plan’s service area).
- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B (see Section 8 for information about staying enrolled in Part A and Part B). [If you have Part B-only grandfathered members, mention that these members need to stay continuously enrolled in Medicare Part B].
- If you give us information on your enrollment form that you know is false or deliberately

misleading, and it affects whether or not you can enroll in Sample Plan.

- If you behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects our ability to arrange or provide medical care for you or for others who are members of Sample Plan. We cannot make you leave Sample Plan for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your plan membership card to get medical care. Before we ask you to leave Sample Plan for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.
- [Delete this bullet if not applicable] If you do not pay the plan premiums, we will tell you that you have a 90-day grace period during which you can pay the plan premiums before you are required to leave Sample Plan.

You have the right to make a complaint if we ask you to leave Sample, Inc.

If we ask you to leave Sample Plan, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to. [If there are specific State requirements regarding involuntary disenrollment and/or if your members have other state-mandated rights regarding the grievance process, describe them here.]

SECTION 13 Legal Notices

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Notice about governing law

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State(s) of **[insert name or names of states]** may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare managed care plans, like Sample, Inc. 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, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

[You may include other legal notices, such as a notice of member non-liability or a notice about third party liability. These notices may only be added if they conform to Medicare laws and regulations and/or State laws that do not conflict with Federal laws.]

Section 14 Definitions of some words used in this booklet

[You may insert definitions not included in this model and exclude model definitions not applicable to your contractual obligations with CMS or enrolled Medicare beneficiaries.

If you use any of the following terms in your EOC, you must add a definition of the term, either in each section where you use it or here in Section 14 with a reference from the section where you use it: IPA, Network, PHO, Plan Medical Group, Point of Service (if the plan offers a POS option, also provide definitions of: Allowed Amount, Balance Billing, Coinsurance and Maximum Charge), Prescription [Drug] Benefit Manager.]

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Appeal – Sections 10 and 11 explain about appeals, including the process involved in making an appeal.

Benefit period – For both Sample Plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. [If you offer a more generous benefit period, revise the following sentences to reflect the plan’s benefit period] A benefit period *begins* on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period *ends* when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays. You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 7 tells what is meant by skilled care.)

Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

Centers for Medicare & Medicaid Services (CMS) -- The Federal Agency that runs the Medicare program (CMS was formerly known as the Health Care Financing Administration). Section 1 tells how you can contact CMS.

Covered services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by Sample Plan. Covered services are listed in the Benefits Chart in Section 4.

Disenroll or disenrollment -- The process of ending your membership in Sample Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 12 tells about disenrollment.

Durable medical equipment is equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

Emergency care -- Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

Optional to include: Evidence of coverage and disclosure information -- This document, along with your enrollment form [insert if applicable any reference to attachments, riders or other optional coverage selected], which explains the covered services, defines our obligations, and explains your rights and responsibilities as a member of the Sample Plan.

Grievance – Section 10 explains about grievances.

Medically necessary – Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medicare --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 (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization -- A public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Sample, Inc. is a Medicare Advantage Organization. (Medicare Advantage is the new name for Medicare + Choice).

Medicare Advantage Plan -- A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. Sample Plan is a Medicare Advantage Plan. (Medicare Advantage is the new name for Medicare + Choice).

Medicare Cost Plan – A specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all people with Medicare living in the service area covered by the Plan. A company offering a Cost Plan may offer more than one plan in the same service area. Members under this plan may use Original Medicare benefits from any Medicare provider.

“Medigap” (Medicare supplement insurance) policy –Many people who get their Medicare through Original Medicare buy “Medigap” or Medicare supplement insurance policies to fill “gaps” in Original Medicare coverage.

Member (member of Sample Plan, or “plan member”)– A person with Medicare who is eligible to get covered services, who has enrolled in Sample Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member services -- A department within Sample, Inc. responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to

contact Member Services.

Non-plan provider or non-plan facility -- A provider or facility that we have **not** arranged with to coordinate or provide covered services to members of Sample Plan. Non-plan providers are providers that are not employed, owned, or operated by Sample, Inc. and are not under contract to deliver covered services to you. As explained in this booklet, you may pay more if you see non-plan providers unless it is for emergency. [Include a sentence or two explaining how the organization pays non-plan providers (for example, that the organization will make a payment based on the lesser of the actual charges or the Medicare Allowed Amount).]

Include if applicable: Optional supplemental benefits -- Non-Medicare covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. Members of Sample Plan must voluntarily elect Optional Supplemental Benefits in order to get them.

Original Medicare -- A plan that is available everywhere in the United States. Some people call it “traditional Medicare” or “fee-for-service” Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Plan provider – “**Provider**” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**plan providers**” when they are part of Sample Plan. When we say that plan providers are “part of Sample Plan,” this means that we have arranged with them to coordinate or provide covered services to members of Sample Plan. Sample, Inc. pays plan providers based on the contracts it has with the providers.

[PPO Demonstrations that use PCPs include this definition] **Primary Care**

[Physician/Provider] (PCP) -- A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about PCPs.

Prior authorization Approval in advance to get services. Some services are covered only if your doctor or other plan provider gets “prior authorization” from [organization name/ [name of group or department that gives prior authorizations]]. Covered services that need prior authorization are marked in the Benefits Chart.

Quality Improvement Organization (QIO)-- Groups of practicing doctors and other health care experts who are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 10 for information about making complaints to the QIO.

[If applicable, don't include this definition] **Referral** -- Your PCP's [“or his/her plan medical group” or “IPA's”] approval for you to see a certain plan specialist or to receive certain covered services from plan providers.

Rehabilitation services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider. See Section 7 for more information.

Service area -- Section 2 tells about Sample Plan's service area. "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Urgently needed care – Section 3 explains about urgently needed services. These are different from emergency services.