EVIDENCE OF COVERAGE

2025

METROPLUS ADVANTAGE PLAN (HMO D-SNP)

Metro Plus Health

January 1 – December 31, 2025

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of MetroPlus Advantage Plan (HMO D-SNP)

This document gives you the details about your Medicare and Medicaid health care, long-term care, including home and community-based services as applicable and prescription drug coverage, from January 1 through December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 866.986.0356. (TTY users should call 711). Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free.

This plan, MetroPlus Advantage Plan (HMO D-SNP), is offered by MetroPlus Health Plan, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means MetroPlus Health Plan, Inc. When it says "plan" or "our plan," it means MetroPlus Advantage Plan (HMO D-SNP).

- MetroPlus Health Plan provides free aids and services to people with disabilities to help you communicate with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats). If you need these services, call MetroPlus Health Plan at 1.866.986.0356. For TTY/TDD services, call 711.
- We also provide free language services to people whose first language is not English, such as qualified interpreters, and information written in other languages. Call New York Medicaid Choice at 800.541.2831 if you need interpreter services or program information in Braille or on CD. TTY users: 888.329.1541. Counselors are available to help explain or answer questions relating to enrollment.
- If you want to change how you receive materials, you can request the change at any time by calling our Member Services number at 866.986.0356 (TTY: 711). Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. The call is free.
- If you want to change or update your contact information, you can request the change at any time by calling Member Services at 866.986.0356 (TTY: 711). Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. The call is free.
- For more information about Medicare, you can read the Medicare & You handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can access it online at the Medicare website (medicare.gov) or request a copy by calling 1-800-MEDICARE (800.633.4227), 24 hours a day, 7 days a week. TTY users should call 877.486.2048.

- You can get this document for free in other formats, such as large print, braille, or audio. Call Member Services at 866.986.0356 (TTY: 711). Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. The call is free.
- This document is available for free in Spanish and traditional Chinese.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2026.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

2025 Evidence of Coverage

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CHAPTER 1:
Getting started as a member

OMB Approval 0938-1051 (Expires: August 31, 2026)

SECTION 1 Introduction

Section 1.1 You are enrolled in MetroPlus Advantage Plan (HMO D-SNP), which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and Medicaid:

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and Medicaid health care your prescription drug coverage through our plan, MetroPlus Advantage Plan (HMO D-SNP). MetroPlus Advantage Plan (HMO D-SNP) members in our companion Medicaid managed care plan will also receive their Medicaid benefits through our plan. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

MetroPlus Advantage Plan (HMO D-SNP) is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. MetroPlus Advantage Plan (HMO D-SNP) is designed for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you get assistance from Medicaid with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. Medicaid also provides other benefits to you by covering health care services that are not usually covered under Medicare. You may also receive "Extra Help" from Medicare to pay for the costs of your Medicare prescription drugs. MetroPlus Advantage Plan (HMO D-SNP) will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

MetroPlus Advantage Plan (HMO D-SNP) is run by a nonprofit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the New York State Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, long-term care, including home and community-based services as applicable and prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility

requirement. Please visit the Internal Revenue Service (IRS) website at: **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

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

This *Evidence of Coverage* document tells you how to get your Medicare and Medicaid medical care, long-term care, including home and community-based services as applicable and prescription drug coverage . It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care, long-term care and including home and community-based services and the prescription drugs available to you as a member of MetroPlus Advantage Plan (HMO D-SNP).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned or just have a question, please contact Member Services.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how MetroPlus Advantage Plan (HMO D-SNP) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for months in which you are enrolled in MetroPlus Advantage Plan (HMO D-SNP) between January 1, 2025 and December 31, 2025.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of MetroPlus Advantage Plan (HMO D-SNP) after December 31, 2025. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2025.

Medicare (the Centers for Medicare & Medicaid Services) must approve MetroPlus Advantage Plan (HMO D-SNP) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B.
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States.
- -- *and* -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and Full Medicaid Benefits or eligible for Medicare cost-sharing assistance under Medicaid.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within 3 month(s), then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

Section 2.2 What is Medicaid?

Medicaid is a joint Federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

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

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

- **Qualifying Individual (QI):** Helps pay Part B premiums.

Section 2.3 Here is the plan service area for MetroPlus Advantage Plan (HMO D-SNP)

MetroPlus Advantage Plan (HMO D-SNP) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in New York: Bronx, Kings (Brooklyn), Queens, Richmond (Staten Island), and New York (Manhattan).

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Services to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

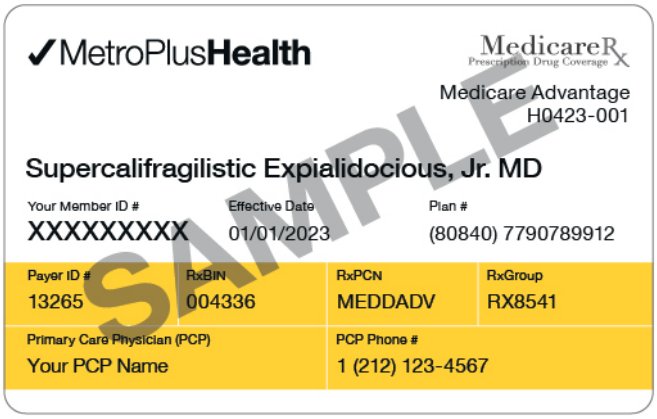
Section 2.4 U.S. Citizen or Lawful Presence

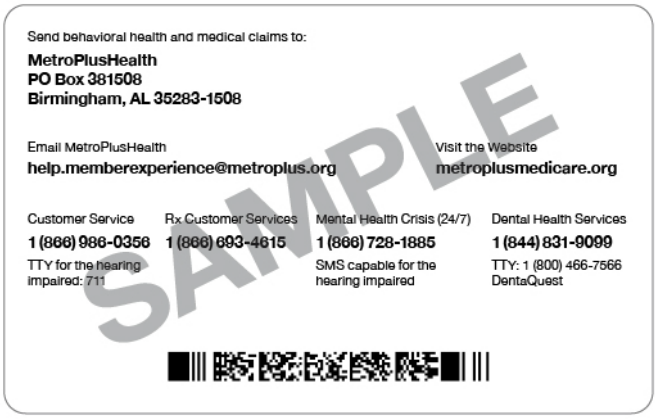
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify MetroPlus Advantage Plan (HMO D-SNP) if you are not eligible to remain a member on this basis. MetroPlus Advantage Plan (HMO D-SNP) must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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





Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your MetroPlus Advantage Plan (HMO D-SNP) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Section 3.2 Provider/Pharmacy Directory

The Provider/Pharmacy Directory lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and

cases in which MetroPlus Advantage Plan (HMO D-SNP) authorizes use of out-of-network providers.

The most recent list of providers and suppliers is available on our website at **metroplusmedicare.org**. If you don't have your copy of the Provider/Pharmacy Directory, you can request a copy electronically or in hardcopy from Member Services.

The Provider/Pharmacy Directory lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the Provider/Pharmacy Directory to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have your copy of the Provider/Pharmacy Directory, you can request a copy (electronically or in hardcopy form) from Member Services. Requests for hard copy Provider Directories will be mailed to you within three business days. You can also find this information on our website at **www.metroplusmedicare.org**.

Section 3.3 The plan's List of Covered Drugs *(Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in MetroPlus Advantage Plan (HMO D-SNP). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the MetroPlus Advantage Plan (HMO D-SNP) Drug List.

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

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (**metroplus.org/plans/medicare**) or call Member Services.

SECTION 4 Your monthly costs for MetroPlus Advantage Plan (HMO D-SNP)

Your costs may include the following:

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

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you**. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the *LIS Rider*.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2025* handbook, the section called *2025 Medicare Costs* If you need a copy, you can download it from the Medicare website (**medicare.gov/medicare-and-you**). Or you can order a printed copy by phone at 1-800-MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users call 1.877.486.2048.

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. For 2025 the monthly premium for MetroPlus Advantage Plan (HMO D-SNP) is $0 or up to $71.20 depending on your level of Medicaid eligibility. All or most of your $71.20 plan premium is paid on your behalf by Extra Help.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most MetroPlus Advantage Plan (HMO D-SNP) members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A, which affects members who aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Because you are dually-eligible, the LEP doesn't apply to you as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in MetroPlus Advantage Plan (HMO D-SNP), we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Veterans Health Administration (VA). Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

- **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
- **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024 this average premium amount was $34.70. This amount may change for 2025.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $34.70, which equals $4.85. This rounds to $4.90. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

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

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

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

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit **medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans**.

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

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1.800.772.1213 (TTY 1.800.325.0778).

Section 4.5 Medicare Prescription Payment Plan Amount

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

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

SECTION 5 More information about your monthly premium

Section 5.1 If you pay a Premium, there are several ways you can pay your premium

There are two ways you can pay the premium. To change the way you pay your premium & Part D late enrollment penalty, please call Member Services.

Option 1: Paying by check

You may decide to make your payment directly to our Plan with a check or money order. You will receive an invoice from our Plan every month. Please make payment payable to "MetroPlus Health Plan". Do not make your check or money order payable to "CMS" or "HHS".

Payments should be sent to:

MetroPlus Health Plan
P.O. Box 30327
New York, NY 10087

Full payment must be received by the end of the month in which you get the invoice. For example, your January monthly premium is due by January 31.

Option 2: Having your Premium or Part D late enrollment penalty taken out of your monthly Social Security check

Changing the way you pay your premium. If you decide to change the option by which you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time. To change your Part D late enrollment penalty, please call Member Services.

What to do if you are having trouble paying your plan premium

If you are required to pay a plan premium payment, that plan premium payment is due in our office by the last day of the month. If we have not received your payment by the last day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your plan premium payment, if owed, within 90 days. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying plan premium, if owed, on time, please contact Member Services to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay Part D late enrollment penalty or premiums, you will have health coverage under Original Medicare. As long as you are receiving "Extra Help" with your prescription drug costs, you will continue to have Part D drug coverage. Medicare will enroll you into a new prescription drug plan for your Part D coverage.

At the time we end your membership, you may still owe us for the penalty you have not paid. We have the right to pursue collection of the amount you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 9 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your Part D late enrollment penalty, if owed, within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 9, Section 11 of this document tells how to make a complaint, or you can call us at 1.866.986.0356, Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free. You must make your request no later than 60 days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home

- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, please let us know by calling Member Services.

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

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

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

  - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2:
Important phone numbers and resources

SECTION 1 MetroPlus Advantage Plan (HMO D-SNP) contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to MetroPlus Advantage Plan (HMO D-SNP) Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	866.986.0356 Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free
FAX	212.908.5196
WRITE	MetroPlus Health Plan 50 Water Street, 7th fl. New York, NY 10004 Attn: Medicare Department
WEBSITE	**metroplusmedicare.org**

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions and Appeals for Medical Care or Part D prescription drugs – Contact Information
CALL	866.986.0356 Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free.
FAX	Coverage Decisions: 212.908.4401 Appeals: 212.908.8824
WRITE	Coverage Decisions: MetroPlus Health Plan Utilization Management 50 Water Street, 7th fl. New York, NY 10004 Appeals: Regular Mail: MetroPlus Health Plan Appeals Coordinator 50 Water Street, 7th fl. New York, NY 10004 Delivery in Person: MetroPlus Health Plan Appeals Coordinator 50 Water Street, 7th fl. New York, NY 10004
WEBSITE	**metroplusmedicare.org**

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

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*.

Method	Complaints about Medical Care – Contact Information
CALL	866.986.0356 Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free.
FAX	212.908.5196
WRITE	MetroPlus Health Plan Complaints Manager 50 Water Street, 7th fl. New York, NY 10004
MEDICARE WEBSITE	You can submit a complaint about MetroPlus Advantage Plan (HMO D-SNP) directly to Medicare. To submit an online complaint to Medicare, go to **medicare.gov/MedicareComplaintForm/home.aspx**.

Where to send a request asking us to pay our share of the cost for medical care or a drug you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*) for more information.

Method	Payment Requests – Part C Medical Claims - Contact Information
WRITE	MetroPlus Health Plan Complaints Manager 50 Water Street, 7th fl. New York, NY 10004
WEBSITE	**metroplusmedicare.org**
Method	**Payment Requests – Part D Prescription Drug Bills - Contact Information**
CALL	866.693.4615 Calls to this number are free.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
FAX	855.633.7673
WRITE	CVS Caremark Paper Claims Department – RxClaim P.O. Box 52066 Phoenix, AZ 85072-2066
WEBSITE	**metroplusmedicare.org**

How to contact DentaQuest, our dental vendor

Dental services must be obtained through the DentaQuest dental network (see Chapter 4 for information about your dental benefits).

Method	DentaQuest
FAX	262.834.3589
WRITE	DentaQuest P.O. Box 2906 Milwaukee, WI 53201-2906
COURIER	Via FedEx or other courier at street address: 11100 W. Liberty Drive Milwaukee, WI 53224

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1.800.633.4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1.877.486.2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	**www.Medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

Method	Medicare – Contact Information
WEBSITE (continued)	You can also use the website to tell Medicare about any complaints you have about MetroPlus Advantage Plan (HMO D-SNP): • **Tell Medicare about your complaint:** You can submit a complaint about MetroPlus Advantage Plan (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.)

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New York, the SHIP is called Health Insurance Information, Counseling and Assistance Program (HIICAP).

HIICAP is an independent (not connected with any insurance company or health plan) state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

HIICAP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. HIICAP counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit **www.shiphelp.org** (Click on SHIP LOCATOR in middle of page)
- Select your STATE from the list. This will take you to a page with phone numbers and resources specific to your state.

Method	Health Insurance Information, Counseling and Assistance Program (HIICAP*)* (New York SHIP) – Contact Information
CALL	800.701.0501
WRITE	New York City Department for the Aging 2 Lafayette Street, 9th fl. New York, NY 10007-1392
WEBSITE	**nyconnects.ny.gov**

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For New York, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

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

Method	Livanta (New York's Quality Improvement Organization) – Contact Information
CALL	866.815.5440 Monday through Friday, 9am to 5 pm
TTY	866.868.2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	**livantaqio.com**

SECTION 5 Social Security

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

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

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

Method	Social Security – Contact Information
CALL	1.800.772.1213 Calls to this number are free. Available 8am to 7pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1.800.325.0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8am to 7pm, Monday through Friday.
WEBSITE	**ssa.gov**

SECTION 6 Medicaid

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

MetroPlus Advantage Plan (HMO D-SNP) members are dually enrolled with both Medicare and Medicaid.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

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

If you have questions about the assistance you get from Medicaid, contact the New York State Department of Health Medicaid Program.

You can get help and information from Medicaid

For questions or assistance, contact New York State Medicaid. To get information from Medicaid, you can call the New York State Department of Health Medicaid Program at 800.541.2831 (TTY: 888.329.1541). You can also visit the New York Medicaid website (**health.ny.gov/health_care/medicaid/ldss.htm**).

Method	New York State's Medicaid Program – Contact Information
CALL	800.541.2831 Mon. - Fri., 8:00am – 8:00pm; Sat., 9:00am - 1:00pm
TTY	711
WRITE	You can write to your Local Department of Social Services (LDSS) Find the address for your LDSS at **health.ny.gov/health_care/medicaid/ldss.htm**
WEBSITE	**health.ny.gov/health_care/medicaid/ldss.htm**

Method	Community Health Advocates (CHA) - Contact Information
CALL	888.614.5400 Mon. - Fri., 9:00am - 4:00pm
TTY	711
WRITE	Community Health Advocates Community Service Society of New York 633 Third Ave, 10th fl. New York, NY 10017 **email**: **cha@cssny.org**
WEBSITE	**communityhealthadvocates.org/**

Method	Independent Consumer Advocacy Network (ICAN) - Contact Information This ombudsman can help our enrollees who are in our Medicaid Health and Recovery Plan (HARP); or who are in our Medicaid Managed Care (MMC) and get long term services and supports.
CALL	844.614.8800 Mon. - Fri. 9:00am – 5:00pm
TTY	711
WRITE	Independent Consumer Advocacy Network (ICAN) Community Service Society of New York 622 Third Ave, 10th fl. New York, NY 10017 **email**: **ican@cssny.org**
WEBSITE	**icannys.org/**

The New York State Office of Long Term Care Ombudsman program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	New York State Office of Long Term Care Ombudsman Program - Contact Information
CALL	855.582.6769
WRITE	2 Empire State Plaza, 5th fl. Albany, NY 12223 **email**: **ombudsman@aging.ny.gov**
WEBSITE	**aging.ny.gov/long-term-care-ombudsman-program**

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

The Medicare.gov website (**medicare.gov/basics/costs/help/drug-costs**) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

If you have questions about "Extra Help," call:

- 1-800-MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1.800.772.1213, between 8 am and 7 pm, Monday through Friday. TTY users should call 1.800.325.0778; or
- Your State Medicaid Office (See Section 6 of this chapter for contact information).

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- To request assistance with obtaining best available evidence or information on how to send it to MetroPlus Health Plan, call Member Services (phone numbers are on the back of this booklet).
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

Most of our members qualify for and are already getting "Extra Help" from Medicare to pay for their prescription drug plan costs.

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

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

New York's State Pharmaceutical Assistance Program (SPAP) is called the Elderly Pharmaceutical Insurance Coverage (EPIC) program. It helps low- to moderate-income seniors age 65 and older pay for prescription drugs. You can call 1.800.332.3742 (TTY 1.800.290.9138) for more information or to request an application.

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

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through the HIV Uninsured Care Program, ADAP.

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call HIV Uninsured Care Program, ADAP at 800.542.2437, TTY 518.459.0121, Monday through Friday from 9am to 5pm.

State Pharmaceutical Assistance Programs

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

In New York, the State Pharmaceutical Assistance Program is the Elderly Pharmaceutical Insurance Program (EPIC).

Method	EPIC (New York's State Pharmaceutical Assistance Program) – Contact Information
CALL	800.332.3742 Monday through Friday, 8:30am to 5pm
TTY	800.290.9138 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	EPIC P.O. Box 15018 Albany, NY 12212-5018 Email: **nysdohepic@magellanhealth.com**
WEBSITE	**health.ny.gov/health_care/epic**

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. Contact us or visit **Medicare.gov** to find out if this payment option is right for you.

Method	The Medicare Prescription Payment Plan – Contact Information
CALL	866.986.0356 Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free
FAX	212.908.5196
WRITE	MetroPlus Health Plan 50 Water Street, 7th fl. New York, NY 10004 Attn: Medicare Department
WEBSITE	**www.metroplusmedicare.org**

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency

Method	Railroad Retirement Board – Contact Information
CALL	1.877.772.5772 Calls to this number are free. If you press "0", you may speak with an RRB representative from 9am to 3:30pm, Monday, Tuesday, Thursday, and Friday, and from 9am to 12pm on Wednesday. If you press "1", you may access the automated RRB Help Line and recorded information 24 hours a day, including weekends and holidays.
TTY	1.312.751.4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	**rrb.gov**

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1.800.633.4227; TTY: 1.877.486.2048) with questions related to your Medicare coverage under this plan.

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

CHAPTER 3:
Using the plan for your medical services

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

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for covered services.
- **Covered services** include all the medical care, health care services, supplies equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare and Medicaid health plan, MetroPlus Advantage Plan (HMO D-SNP) must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare.

MetroPlus Advantage Plan (HMO D-SNP) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a referral. For more information about this, see Section 2.3 of this chapter.
    - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
    - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
    - If you need medical care that Medicare or Medicaid requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
    - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

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

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your care

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

When you become a member of our Plan, you must choose a plan provider to be your PCP. Your PCP is a physician or nurse practitioner 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 member of our Plan. For example, in order for you to see a specialist, you usually need to consult with your PCP first. Your PCP will refer you to a specialist. Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan.

This includes, but is not limited to:

- X-rays
- Laboratory tests
- Therapies
- Care from 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, you must get approval in advance from your PCP. In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

How do you choose your PCP?

You may have already picked your PCP to serve as your regular doctor. This person could be a doctor or a nurse practitioner. You may choose a PCP by using our Provider/Pharmacy Directory that lists the address, phone number, and special training of the doctors. You should call your PCP's office to make sure she/he takes new patients. Once you choose a PCP, please call our Member Services department so that we can update our records. If you have not chosen a PCP, you should do so right away. If you do not choose a PCP within 30 days from the date you become a member of our plan, we will choose one for you.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

Please call our Member Services department and we can help you choose a new PCP. If you call us to change your PCP on or before the 15th of the month, your PCP change will be effective as of the first of that month. If you call us after the 15th of the month, it will be effective as of the first of the next month.

If your PCP leaves our network, you may be able to continue seeing them for a transitional period of time (90 days). You or your PCP must contact Member Services in advance to arrange this.

Section 2.2 What kinds of medical care can you get without a referral from your PCP?

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots (or vaccines), COVID-19 vaccinations Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed plan-covered services, which are services requiring immediate medical attention that are not emergencies, provided you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.

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

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

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

There are some medical services that require permission from MetroPlus Health Plan in order for the Plan to pay for these services. Please see Chapter 4, Section 2.1 for information about which services require prior authorizations or prior approvals. In general, the health care provider who orders the service will arrange to obtain the Prior Authorization from the plan. In order to approve the request, the health care provider will provide the Plan with medical information to explain your need for the service being requested. In an emergency, the physician/hospital must notify us as soon as possible. Briefly, the following services require Prior Authorization from the Plan.

- All services by out-of-network providers including physicians, hospitals, DME vendors and other out-of-network providers.
- All inpatient hospital admissions (medical, surgical, acute rehabilitation, sub-acute rehabilitation, skilled nursing facility, inpatient drug or alcohol admissions, or psychiatric inpatient admissions).
- Planned or elective hospital admissions must be authorized no later than 7 days prior to the anticipated date of admission.
- All durable medical equipment must be prior authorized. In this case, either the physician ordering the equipment or the company providing the equipment will obtain the prior authorization.
- All home care services covered by the Plan must also be prior authorized. Again, the health care provider ordering these services will generally obtain the prior authorization. Sometimes, the agency that provides the home care services will obtain the prior authorization.
- Special X-ray procedures such as outpatient CT scans (computerized tomography), PET scans (Positron Emission Tomography), MRI scans (Magnetic Resonance Imaging), or other high technology X-ray tests must also receive prior authorization from our radiology vendor. The ordering physician/provider should contact our radiology vendor for additional information.

Once a request for a prior authorization is received by MetroPlus Health Plan, one of the Plan's medical directors will review the request to determine whether the service requested is medically necessary and a covered benefit. In some cases, such as special X-ray tests noted above, MetroPlus will have a special outside physician review the request and make the decision regarding the test.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. You must obtain prior authorization before obtaining service.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

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

If we do not have a specialist in MetroPlus Health Plan who can give you the care you need, we will get you the care you need from a specialist outside the network. Before you can see the specialist, your doctor must ask MetroPlusHealth for a prior authorization.

To get the prior authorization, your doctor must give us some information. Once we get all this information, we will decide within 14 calendar days from the date of your request if you can see

the out-of- network specialist. You or your doctor can ask for a fast track review if your doctor feels that a delay will cause serious harm to your health. In that case, we will decide and get back to you in 72 hours. Please call our Customer Service for more information.

Note: Members are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover dialysis services for ESRD members who have traveled outside the plan's service area and are not able to access contracted ESRD providers.

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

Section 3.1 Getting care if you have a medical emergency

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

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it. However, our plan covers Emergency care both in the U.S. and worldwide (outside the U.S.) all though Medicare does not provide coverage for emergency medical care outside the United States and its territories.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Phone numbers are listed on the back of this booklet.

What is covered if you have a medical emergency?

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

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

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

If you have an emergency care outside of the U.S. and its territories, you will be responsible to pay for those services upfront and request appropriate reimbursement from us. For those covered, medically necessary, emergency services received outside of the U.S. and its territories, Advantage Plan (HMO D-SNP) will determine reimbursement based on the (local market) reasonable charges, currency exchange when required, and the applicable benefit category. Since foreign providers might charge more for services than the rates at which Original Medicare would pay, the total of our reimbursement for those services may be less than the amounts you paid to the foreign provider. You will be reimbursed based on the covered service rendered. This represents payment in full. You may be responsible for amounts in excess of our payment amount. If you elect to receive noncovered services, you are responsible for the entire charge associated with the noncovered service. This is a supplemental benefit not generally covered by Medicare. You must submit proof of payment to MetroPlus Health for reimbursement. See Chapter 4 (Medical Benefits Chart, what is covered and what you pay) for more information. If you have already paid for the covered services, we will reimburse you.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – The additional care you get is considered urgently needed services and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

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

What are urgently needed services?

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However,

medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

To access urgently needed services, you can visit an Urgent Care facility. You can find a list of participating Urgent Care facilities in your Provider/Pharmacy Directory, or on our website. You can also contact your PCP or Member Services for help arranging care.

Our plan does not cover urgently needed services for care received outside of the United States and its territories.

Section 3.3 Getting care during a disaster

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

Please visit the following website: **metroplus.org** for information on how to obtain needed care during a disaster.

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

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

Section 4.1 You can ask us to pay our share of the cost for covered services

If you have paid more than your plan cost sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2 What should you do if services are not covered by our plan?

MetroPlus Advantage Plan (HMO D-SNP) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. For all Medicare-covered services, the out-of-pocket costs you pay for these benefits after you have reached the benefit limit will not count toward your annual out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a clinical research study?

Section 5.1 What is a clinical research study?

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations requiring coverage with evidence development (NCDs-CED)

and investigational device exemption (IDE) studies and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

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

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

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- An operation or other medical procedure if it is part of the research study
- Treatment of side effects and complications of the new care

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

> *Here's an example of how the cost sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.

- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.
- Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies*. (The publication is available at: **medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf**) You can also call 1-800-MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

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

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.

- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
    - – *and* – You must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Your stay in the religious nonmedical health care institution is not covered by our plan unless you obtain authorization (approval) in advance from our Plan. Coverage for approved stays in a religious non-medical health care institution will be the same as for Inpatient Hospital Care (see the Benefits Chart in Chapter 4 for more information).

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of MetroPlus Advantage Plan (HMO D-SNP), however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances, we will transfer ownership of the DME item to you. Call member services for more information.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.
Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own

the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage MetroPlus Advantage Plan (HMO D-SNP) will cover:

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

If you leave MetroPlus Advantage Plan (HMO D-SNP) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

CHAPTER 4:
Medical Benefits Chart (what is covered and what you pay)

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

This chapter provides a Medical Benefits Chart that lists your covered services as a member of MetroPlus Advantage Plan (HMO D-SNP). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- **Deductible** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your plan deductible.) (Section 1.3 tells you more about your deductibles for certain categories of services.)
- **Copayment** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for full Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments, or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. For all other members, your cost-sharing will depend on your level of "Extra Help" and/or level of Medicaid assistance.

Section 1.2 What is your plan deductible?

Your deductible is $0 or $240*. Until you have paid the deductible amount, you must pay the full cost of your covered services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The deductible does not apply to some services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible does not apply to the following services:

- Medicare-covered preventive services
- Emergency Services

- Urgently Needed Services
- Insulin furnished through an item of durable medical equipment.

If you are eligible for Medicare cost-sharing assistance under Medicaid, you have no deductible.

*These are 2024 amounts and may change for 2025. MetroPlus Advantage Plan (HMO D-SNP) will provide updated amounts as soon as they are released by CMS.

Section 1.3 Our plan also has a deductible for certain types of services

In addition to the plan deductible that applies to all of your covered medical services, we also have a deductible for certain types of services.

The plan has a deductible amount for the following types of services:

- Our deductible amount for Inpatient Hospital Care is $1,632* per benefit period. Until you have paid the deductible amount, you must pay the full cost for Inpatient Hospital Care. Once you have paid your deductible, we will pay our share of the costs for these services, and you will pay your share (your copayment) for each benefit period. The benefits chart in Section 2 shows the service category deductibles.
- Our deductible amount for Inpatient Mental Health Care is $1,632* per benefit period. Until you have paid the deductible amount, you must pay the full cost for Inpatient Mental Health Care. Once you have paid your deductible, we will pay our share of the costs for these services, and you will pay your share (your copayment) for each benefit period. The benefits chart in Section 2 shows the service category deductibles.

If you are eligible for Medicare cost-sharing assistance under Medicaid, you have no deductible.

*These are 2024 amounts and may change for 2025. MetroPlus Advantage Plan (HMO D-SNP) will provide updated amounts as soon as they are released by CMS.

Section 1.4 What is the most you will pay for Medicare Part A and Part B covered medical services?

Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out of-pocket amount for covered Part A and Part B services.

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B *OR* by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2025 this amount is $9,350.

The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of $9,350, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.5 Our plan does not allow providers to balance bill you

As a member of MetroPlus Advantage Plan (HMO D-SNP), an important protection for you is that after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers

services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)

- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or outside the service area for urgently needed services.)

- If you believe a provider has balance billed you, call Member Services.

We do not allow providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service. If you receive a bill from a provider, call Member Services.

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

Section 2.1 Your medical benefits as a member of the plan

The Medical Benefits Chart on the following pages lists the services MetroPlus Advantage Plan (HMO D-SNP) covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a referral.

- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk.

Other important things to know about our coverage:

- You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services. Medicaid also covers services Medicare does not cover, like long-term services and supports, and over-the-counter drugs.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* handbook. View it online at **medicare.gov** or ask for a copy by calling 1-800-MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.
- The MetroPlus Advantage Plan is a Dual-Eligible Special Needs Plan (D-SNP) that offers Medicare coverage with added-on benefits as well as services you may be entitled to receive under New York State's Medicaid program. Members who have both Medicare and Medicaid are known as dual eligibles. For a description of additional Medicaid benefits and services available to MetroPlus Advantage Plan (HMO D-SNP) members, please see Chapter 4, Section 3.1.
- If you are within our plan's 3-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, the plan is not liable for more than plan premium and cost-sharing amounts owed by members who have not lost their special needs status. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.
- However, during this period, your Medicaid benefits provided by New York State might not be available to you. Please contact the New York State Medicaid Program (you can find phone numbers and contact information for New York State Medicaid in Chapter 2, Section 6). Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.

If you are eligible for Medicare cost-sharing assistance under Medicaid, you do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above

Important Benefit Information for Enrollees with Certain Chronic Conditions

- If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
    - Chronic alcohol and other drug dependence; autoimmune disorders; cancer; cardiovascular disorders; chronic heart failure; dementia; diabetes; end-stage liver disease; end-stage renal disease (ESRD); severe hematologic disorders; chronic and disabling mental health conditions; neurologic disorders; stroke; Alzheimer's Disease; hyperlipidemia; malnutrition/undernutrition; osteoporosis; kidney disease.
- Eligible members will be identified by the Medical Management department based on the chronic conditions list. Members will be sent a letter and brochure about the program and offered the opportunity to participate in care management including nutritional guidance. Your Care Manager can review the nutritional program and enroll you if you are interested.
- Please go to the Special Supplemental Benefits for the Chronically Ill row in the below Medical Benefits Chart for further detail.
- Please contact us to find out exactly which benefits you may be eligible for.

Important Benefit Information for Enrollees Who Qualify for "Extra Help":

- If you receive "Extra Help" to pay your Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.
- Please go to the Medical Benefits Chart in Chapter 4 for further details.

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

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain* Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance. *Prior authorization is required.

Services that are covered for you	**What you must pay** when you get these services
Acupuncture for chronic low back pain (continued) Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Acupuncture (Supplemental)* Our plan also covers an additional 20 supplemental visits per year for other conditions, including chronic low back pain. Members must use a participating network provider.	$0 copay. *Prior authorization is required.
Ambulance services* Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance. *Prior authorization is required for non-emergency services.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Annual Physical Exam (Supplemental) Our plan also covers **Annual Physical Exam** as supplemental benefit.	$0 copay.

Services that are covered for you	**What you must pay** when you get these services
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services* Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance. *Prior authorization is required for nonemergency services.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	**What you must pay** when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services* Covered services include: • We cover only manual manipulation of the spine to correct subluxation	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance. *Prior authorization is required for non-emergency services.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance.

Services that are covered for you	**What you must pay** when you get these services
Colorectal cancer screening (continued) • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	
Dental services* In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. We cover Medicare-covered dental services including: • For otherwise noncovered procedures or services (e.g., tooth removal), if performed by a dentist incident to and as an integral part of an otherwise covered procedure, then the total service performed by the dentist is covered. • Extractions of teeth to prepare jaw for radiation treatment of neoplastic disease. • Dental exams prior to kidney transplantation. **There are no annual maximum limits for covered services. Some services are subject to plan's frequency limits and prior authorization.**	$0 copay for covered preventive and comprehensive services. $0 copay for covered preventive and diagnostic services. Services must be obtained through the DentaQuest dental network. *Prior authorization is required.

Services that are covered for you	**What you must pay** when you get these services
Dental services* (continued) **Preventive Services:** Members are eligible for 1 visit every 6 months for each of the following services: **Dental services* (continued)** • Oral Exams • Prophylaxis (Cleaning) • Fluoride Treatment • Dental X-rays **Restorative services:** Limited to crowns - single restoration, 1 every 60 months per tooth fillings are covered every 24 months: • Post and core in addition to crown, indirectly fabricated • Each additional indirectly fabricated post ‑ same tooth • Prefabricated post and core in addition to crown Limited to crowns - single restoration, selected types shown below only, 1 every 60 months per tooth **Endodontics services:** Limited to root canal therapy, 1 per lifetime per tooth: • Endodontic therapy – molar tooth (excluding final restoration) • Retreatment of previous root canal therapy ‑ molar toot **Periodontics services:** • Limited to osseous surgery ‑ including elevation of a full thickness flap and closure at 1 every 60 months per quad • Gingivectomy or gingivoplasty - four or more contiguous teeth or teeth bounded spaces per quadrant- every 12 months • Clinical crown lengthening- one per lifetime. • Periodontal scaling and root planning - four or more teeth per quadrant- one every two years.	

Services that are covered for you	**What you must pay** when you get these services
Dental services* (continued) **Removable and fixed prosthodontics services:** • Resin-based composite (indirect) • Resin with noble, or high noble metal • Resin with predominantly base metal • Porcelain/ceramic • Porcelain fused to noble or high noble metal • Porcelain fused to predominantly base metal • Full cast noble or high noble metal • Complete and partial removable dentures. (adjustments, repairs, rebase and relines) • Full cast predominantly base metal All the above bulleted items apply to fixed dentures (bridges) also. **Implants:** • Medically necessary **Oral and Maxillofacial surgery:** • One per lifetime, same quadrant. • Extractions • Limited oral evaluation **Adjunctive services:** • Office visit for observation- four visits per 12 months • Periodic oral evaluation- one of every six months	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening (continued) We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.

Services that are covered for you	**What you must pay** when you get these services
(glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	
Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance. Diabetic supplies are limited to Abbott diabetic test strips or Ascensia diabetic test strips. If you have a medical reason to use another brand of test strips, your provider must contact Member Services. *Prior authorization is required for diabetic services and supplies.
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We included a copy of our DME supplier directory in our *Provider/Pharmacy Directory*. The list tells you the brands and manufacturers of DME that we will cover. This most recent list of brands, manufacturers, and suppliers is also available in the	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance. *Prior authorization is required. Your cost sharing for Medicare oxygen equipment coverage is 0% or 20% coinsurance.

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies* (continued) *Provider/Pharmacy Directory* on our website at **metroplusmedicare.org**. Generally, MetroPlus Advantage Plan (HMO D-SNP) covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to MetroPlus Advantage Plan (HMO D-SNP*)* and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.) If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*.)	Your cost sharing will not change after being enrolled for 36 months.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition.	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance (up to $110). If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized.

Services that are covered for you	**What you must pay** when you get these services
Emergency care (continued) A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **Worldwide Emergency Care** Emergency care is covered both in the U.S. and worldwide (outside the U.S.). If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for those services upfront and request appropriate reimbursement from us for covered, medically necessary emergency services.	You must return to a network hospital in order for your care to continue to be covered *OR* you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.
Fitness Benefit MetroPlus Advantage Plan (HMO D-SNP) will reimburse you up to $250 every six months for membership at qualifying exercise facilities. Please call Member Services to learn more about your fitness benefit. **Benefit Limitations:** • You will not be reimbursed for memberships in tennis clubs, country clubs, weight-loss clinics, spas, or any other similar facilities. • Lifetime memberships are not eligible for reimbursement. • MetroPlus Advantage Plan (HMO D-SNP) will not provide reimbursement for equipment, clothing, vitamins, or other services that may be offered by the facility (massages, yoga, etc.).	$0 copay.

Services that are covered for you	**What you must pay** when you get these services
Flex Card Members will receive a $475 flex card per quarter (no rollover to next quarter), that can be used to purchase Over the Counter (OTC) items, groceries, Personal Emergency Response System (PERS), bathroom safety devices; telecommunication equipment including telephone sales; telecommunication services including but not limited to prepaid phone services and recurring phone services; computer network/information services; cable, satellite, and other pay television and radio services; and utilities (electric, gas, heating oil, water). Flex card benefit will be part of the Combined Supplemental Benefits package. Unused Flex card balance will expire at the end of each quarter. Amount if unused, does not carry over to the following calendar year. Please call Member Services to learn more about your Flex card benefit.	$0 copay.
Health and wellness education programs A healthy lifestyle program that provides educational and nutritional materials. You will be invited to participate in health-related events, classes, and activities such as health fairs, nutritional classes, virtual learning and health drives.	$0 copay.
Hearing services* Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Our plan also covers the following supplemental hearing services:	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance for Medicare- covered diagnostic hearing and balance exams.

Services that are covered for you	**What you must pay** when you get these services
• Hearing aids (all types) Per Year (maximum benefit of $500 for both ears per year).	*Prior authorization is required for Medicaid-covered hearing services. $0 copay for hearing aid. Hearing aid is limited to $500 for both ears per year. *Prior authorization is required for hearing aid.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copay. *Prior authorization is required.

Services that are covered for you	**What you must pay** when you get these services
Home infusion therapy *	
Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	$0 copay. *Prior authorization is required

Services that are covered for you	**What you must pay** when you get these services
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis</u>: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis</u>: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not MetroPlus Advantage Plan (HMO D-SNP). $0 copay for a one-time hospice consultation.

Services that are covered for you	**What you must pay** when you get these services
Hospice care (continued) For services that are covered by MetroPlus Advantage Plan (HMO D-SNP) but are not covered by Medicare Part A or B: MetroPlus Advantage Plan (HMO D-SNP) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (*What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D prescription drug benefit. Refer to Chapter 6, Section 8 for additional information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care*	
Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services	For each benefit period, depending on your level of Medicaid eligibility, you pay $0 or: • $1,632 deductible A per admission deductible is applied once during the defined benefit period • Days 1-60: $0 copayment per day • Days 61-90: $408 copayment per day • 60 Lifetime Reserve Days: $816 copayment per day * Prior authorization is required. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If MetroPlus Advantage Plan (HMO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at **es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling 1-800-MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048. You can call these numbers for free, 24 hours a day, 7 days a week.	If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. *These are 2024 amounts and may change for 2025. MetroPlus Advantage Plan (HMO D-SNP) will provide updated amounts as soon as they are released by CMS.

Services that are covered for you	**What you must pay** when you get these services
Inpatient Rehabilitation (In Hospital) *	$0 copay. *Prior authorization is required.
Inpatient services in a psychiatric hospital*	
Covered services include mental health care services that require a hospital stay. Our plan covers up to 190 days inpatient services in a free-standing psychiatric hospital in a lifetime. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. As a dual eligible member, you are covered for unlimited inpatient mental health days, as medically necessary, beyond the 190-day lifetime Medicare limit.	For each benefit period, depending on your level of Medicaid eligibility, you pay $0 or: • $1,632 deductible A per admission deductible is applied once during the defined benefit period. • Days 1-60: $0 copayment per day • Days 61-90: $408 copayment per day • 60 Lifetime Reserve Days: $816 copayment per day *Prior authorization is required.

Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay*	
As described in this Medical Benefits Chart, as a dual eligible member, you are covered for unlimited days as medically necessary for inpatient hospital and skilled nursing facility (SNF) care. If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	Depending on your level of Medicaid eligibility: 0% or 20% coinsurance for each primary care provider (PCP) and specialist visit. 0% or 20% coinsurance for laboratory services. 0% or 20% coinsurance for X-rays. 0% or 20% coinsurance for diagnostic radiology, procedures and tests. 0% or 20% coinsurance for therapeutic radiology services. 0% or 20% coinsurance for medical and surgical supplies. 0% or 20% coinsurance for prosthetic devices. 0% or 20% coinsurance for each physical, speech, and occupational therapy visit. *Prior authorization is required for CT/MRI/MRA and PET scans. *Prior authorization is required for prosthetics, medical and surgical supplies.

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued)*	*Prior authorization is required for physical, speech, and occupational therapy services for more than 10 visits in a year.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs*	
These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance. *Some Part B drugs may be subject to Prior Authorization or Step Therapy. Insulin covered under Part B (for example, insulin administered via a pump that qualifies as an item of durable medical equipment (DME)) will not exceed $35 total for a one month's supply and the Medicare Part B deductible will not apply.

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs (continued)* • Transplant/Immunosuppressive Drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • 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 • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn’t cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they’re administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics	

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs (continued)* • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, 0r Darbepoetin Alfa,) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) Effective 4/1/2023, coinsurance for certain Part B rebatable drugs will be reduced, if the drug's price has increased at a rate faster than the rate of inflation. Effective 7/1/2023, insulin covered under Part B (for example, insulin administered via a pump that qualifies as an item of durable medical equipment (DME)) will not exceed $35 total for a one month's supply and the Medicare Part B deductible will not apply. The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: **metroplus.org/Plans/Medicare/prescription-drug-information** We also cover some vaccines under our Part B and most adult vaccines under our Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	
Nutritional/Dietary Benefit The plan covers up to six preventive counseling and/or risk factor reduction visits annually, which must be provided by state-licensed or certified clinical professionals (i.e., physician, nurse, registered dietitian, or nutritionist). Sessions may be individual or group.	You pay $0 copayment. Members will be eligible for six (6) visits per year (Settings: Individual and Group).

Services that are covered for you	**What you must pay** when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services* Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance. *Prior authorization is required for inpatient services only. Prior authorization is not required for first 28 days coverage of medically necessary inpatient or residential treatment for opioid use disorder.

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies*	
Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests.	Depending on your level of Medicaid eligibility: 0% or 20% coinsurance for X-rays. 0% or 20% coinsurance for diagnostic radiology, procedures and tests. 0% or 20% coinsurance for therapeutic radiology services. 0% or 20% coinsurance for medical and surgical supplies. 0% or 20% coinsurance for laboratory services. 0% or 20% coinsurance for each pint of blood (beginning with the fourth pint). *Prior authorization is required for CT/MRI/MRA and PET scans. *Prior authorization is required for medical and surgical supplies.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at **es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling 1-800-MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048. You can call these numbers for free, 24 hours a day, 7 days a week.	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance.
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself	$0 copay.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services (continued) **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at **es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling 1-800-MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance for each individual or group therapy visit.
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance for each physical, occupational, and/or speech language therapy visit. *Prior authorization is required for more than 10 visits in a year.

Services that are covered for you	**What you must pay** when you get these services
Outpatient substance use disorder services Outpatient mental health care for treatment of substance use provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance for each individual or group therapy visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	Depending on your level of Medicaid eligibility: 0% or 20% coinsurance for each outpatient hospital visit. 0% or 20% coinsurance for each ambulatory surgery center visit.

Services that are covered for you	**What you must pay** when you get these services
Over the Counter (OTC) items Includes medicines such as cough and cold syrups, selected medical supplies and other items that may be obtained without a prescription from a health care professional. Over the Counter (OTC) items are now part of the Flex card benefit. Members will receive a $475 flex card per quarter (no rollover to next quarter) that can be used to purchase Over the Counter (OTC) items, groceries, Personal Emergency Response System (PERS), bathroom safety devices; telecommunication equipment including telephone sales; telecommunication services including but not limited to prepaid phone services and recurring phone services; computer network/information services; cable, satellite, and other pay television and radio services; and utilities‑electric, gas, heating oil, water. Flex card benefit will be part of the new Combined Supplemental Benefits package. Unused Flex card balance will expire at the end of each quarter. Amount if unused, does not carry over to the following calendar year. **Please call Member Services to learn more about your Flex card benefit.**	There is no coinsurance, copayment, or deductible for Over the Counter (OTC). $475 flex card per quarter (no rollover to next quarter) that can be used to purchase Over the Counter (OTC) items.

Services that are covered for you	**What you must pay** when you get these services
Partial hospitalization services and Intensive outpatient services*	
Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance. *Prior authorization is required.
Personal Emergency Response System (PERS)	
Personal Emergency Response System (PERS) is covered under the Flex card benefit. Members will receive a $355 flex card per quarter (no rollover to next quarter) that can be used to purchase Over the Counter (OTC) items, groceries, Personal Emergency Response System (PERS), bathroom safety devices; telecommunication equipment including telephone sales; telecommunication services including but not limited to prepaid phone services and recurring phone services; computer network/information services; cable, satellite, and other pay television and radio services; and utilities (electric, gas, heating oil, water). Flex card benefit will be part of the new Combined Supplemental Benefits package. Unused Flex card balance will expire at the end of each quarter. Amount if unused, does not carry over to the following calendar year. **Please call Member Services to learn more about your Flex card benefit.**	There is no coinsurance, copayment, or deductible for Personal Emergency Response System (PERS) benefit. $355 flex card per quarter (no rollover to next quarter) that can be used towards Personal Emergency Response System (PERS).

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: Urgently Needed Services; Physician Specialist Services; Individual Sessions for Mental Health Specialty Services; Other Health Care Professional; Individual Sessions for Psychiatric Services; Individual Sessions for Outpatient Substance Abuse; and Diabetes Self-Management Training. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. o Access to a doctor by using an interactive audio and video telecommunications system such as a tablet or phone that permits real-time interactive communication, 24 hours a day, 7 days a week. Contact your provider to see if they offer telehealth services and/or to make an appointment, or visit our website at **metroplusmedicare.org** for information on how to access our telehealth provider • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	Depending on your level of Medicaid eligibility: 0% or 20% coinsurance for each primary care provider (PCP) **in-person office visit**. 0% or 20% coinsurance for each specialist **in-person office visit**. 0% or 20% coinsurance for diagnostic hearing and balance exams. 0% or 20% coinsurance for each urgently needed services; physician specialist services; individual sessions for mental health specialty services; other health care professional; individual sessions for psychiatric services; individual sessions for outpatient substance abuse; and diabetes self-management training **telehealth visit**. 0% or 20% coinsurance for Medicare-covered non-routine dental care.

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: o You're not a new patient **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	Services must be obtained through the DentaQuest dental network. [Prior authorization is required for nonroutine dental care.]
Podiatry services* Covered services include:	Depending on your level of Medicaid eligibility, you

Services that are covered for you	**What you must pay** when you get these services
Podiatry services* (continued) • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs • Up to 8 routine podiatry visits per year As a dual eligible member, you are entitled to additional Medicaid-covered podiatry services for medically necessary foot care. This includes care for medical conditions affecting lower limbs, and up to four routine foot care visits per year.	pay 0% or 20% coinsurance for Medicare-covered podiatry services. *Prior authorization is required for routine foot care.
Post Discharge Meals* Coverage for up to 20 meals delivered to your home for duration of 5 days after a discharge from inpatient setting to home. Members are eligible for home delivery of meals if they meet the following requirements: • Needed due to an illness • Consistent with established treatment of the illness There is no limit to the number of 5-day meal benefit periods you may receive in a year after a discharge from inpatient setting to home if the above requirements are met. Meals are provided and delivered by the MetroPlus Health Plan contracted vendor. If you have any questions, contact your care manager at 866.986.0356 (TTY: 711).	$0 copay. *Prior authorization is required.
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.

Services that are covered for you	**What you must pay** when you get these services
Prostate cancer screening exams (continued)	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance for Medicare-covered digital rectal exam.
Prosthetic and orthotic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail. As a dual eligible member, you are entitled to additional Medicaid-covered prosthetics, orthotics, and orthopedic footwear.	$0 copay for prosthetic devices. $0 copay for Medicare-covered eyewear after cataract removal or cataract surgery. *Prior authorization is required for prosthetic devices.
Psychiatric Inpatient Services (in Hospital)*	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance. 190-day lifetime maximum. *Prior authorization is required.
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and referral *OR* for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance. *Prior authorization is required

Services that are covered for you	**What you must pay** when you get these services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50-77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive an order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	**What you must pay** when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section **Medicare Part B prescription drugs**.	Depending on your level of Medicaid eligibility: 0% or 20% coinsurance for kidney disease education services. 0% or 20% coinsurance for dialysis treatments.

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care* (For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.) A 3-day prior hospital stay is required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need – you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	For each benefit period, depending on your level of Medicaid eligibility, you pay $0 or: • You pay nothing (days 1-20) • $200 copay per day for days 21-100 *Prior authorization is required.

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care* (continued) As a dual eligible member, you are entitled to additional Medicaid-covered benefits.	*Prior authorization is required.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (continued) If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	

Services that are covered for you	**What you must pay** when you get these services
Supervised Exercise Therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copay *Prior authorization is required.
Transportation (Routine/Non-Emergent) Routine/Non-emergency transportation to an approved provider location to obtain necessary medical care and services is covered. Includes ambulance, ambulette, invalid coach, taxicab, livery, public transportation, or other means appropriate for the medical condition. You must call MetroPlus Advantage Plan (HMO D-SNP) Member Services at least two days in advance of your appointment. The plan will arrange for round-trip transportation to be provided by ModivCare, an approved vendor. MetroPlus Advantage Plan (HMO D-SNP) will not cover the cost of transportation that is not to a plan-approved location by our plan, other than public transportation.	$0 copay for 48 one-way trips per year. (In addition: Members are covered for unlimited rides under their Medicaid coverage.) Please call MetroPlus Advantage Plan (HMO D-SNP) Member Services at least two days in advance. Routine/Non-emergency Transportation will be provided through an approved vendor called Modivcare.

Services that are covered for you	**What you must pay** when you get these services
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. This coverage is available within the United States.	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance (up to $45). Cost-sharing is waived if you are admitted to the hospital within 3 days.
Vision care* Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) MetroPlus Advantage Plan (HMO D-SNP) also covers additional vision care services not covered by Original Medicare.	Depending on your level of Medicaid eligibility, you pay 0% or 20% coinsurance for Medicare-covered eye exams, including diagnosis and treatment of diseases and conditions of the eye. $0 copay for eyewear for up to $450 per year. *Prior authorization may be required for certain Medicaid-covered vision services.

Services that are covered for you	**What you must pay** when you get these services
Vision care* (continued) **Eyewear** Is Eyewear is covered up to a total of $450 per year for: • Contact lenses • Eyeglasses (lenses and frames) • Eyeglass lenses • Eyeglass frames • Upgrades	This benefit can be combined with your Medicaid benefits to provide coverage for additional eyewear, or to purchase eyewear beyond the Medicaid spending limit.
Welcome to Medicare preventive visit The plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.

SECTION 3 What services are covered outside of MetroPlus Advantage Plan (HMO D-SNP)?

Section 3.1 Services *not* covered by MetroPlus Advantage Plan (HMO D-SNP)

MetroPlus Advantage Plan (HMO D-SNP) is a Dual Eligible Special Needs Plan that coordinates your Medicare coverage with additional wrap-around benefits and services you may be entitled to receive under New York State's Medicaid Program or a MetroPlus Medicaid managed care plan. Members who qualify for Medicare and Medicaid are known as dual eligible. As a dual eligible member, you are eligible for benefits under both the federal Medicare Program and the New York State Medicaid Program or a MetroPlus Medicaid managed care plan.

The additional Medicaid benefits you receive may vary based upon your income and resources. With the assistance of Medicaid, some dual eligibles do not have to pay for certain Medicare costs. The Medicaid benefit categories and types of assistance served by our plan are:

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

As a QMB or QMB-Plus, you pay $0 for Medicare-covered services except any copayments for Part D prescription drugs. However, if you are not a QMB or QMB-Plus but qualify for full Medicaid benefits, you may have to pay some copayments, coinsurance, and deductibles, depending on your Medicaid benefits.

The following services are not covered by MetroPlus Advantage Plan (HMO D-SNP) but are available through Medicaid or a MetroPlus Medicaid managed care plan:

Benefit	Description of Medicaid Covered Services	MetroPlus Advantage Plan (HMO D-SNP)
Adult Day Health Care	Medicaid covers Adult Day Health Care services provided in a residential health care facility or approved extension site under the medical direction of a physician. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.	Covered under Medicaid. Covered by MetroPlusHealth Medicaid.
Assisted Living Services	Medicaid covers personal care, housekeeping, supervision, home health aides, personal emergency response services, nursing, physical therapy, occupational therapy, speech therapy, medical supplies and equipment, adult day health care, a range of home health services and the case management services of a registered professional nurse. Services are provided in an adult home or enriched housing setting.	Covered under Medicaid May be covered by MetroPlusHealth for SSI population. *Limitation may apply.
Certain Mental Health Services	Medicaid covers the following mental health services: • Intensive Psychiatric Rehabilitation Treatment Programs • Day Treatment • Continuing Day Treatment	Covered under Medicaid. Covered by MetroPlusHealth Medicaid.

Benefit	Description of Medicaid Covered Services	MetroPlus Advantage Plan (HMO D-SNP)
	• Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units) • Assertive Community Treatment (ACT) • Partial Hospitalizations • Personalized Recovery Oriented Services (PROS)	
Comprehensive Medicaid Case Management	Medicaid covers Comprehensive Medicaid Case Management (CMCM), which provides "social work" case management referral services to a targeted population. A CMCM case manager will assist a client in accessing necessary services in accordance with goals outlined in a written case management plan.	Covered under Medicaid. Covered by MetroPlusHealth Medicaid for targeted populations. *Limitations may apply.
Directly Observed Therapy for Tuberculosis (TB) Disease .	Medicaid covers Tuberculosis Directly Observed Therapy (TB/DOT), which is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen.	Covered under Medicaid. Covered by MetroPlusHealth Medicaid.
Home and Community Based Waiver Program Services	There are a number of Home and Community–Based Waiver Programs that provides services authorized pursuant to SSA Section 1915(c) waivers from DHHS. The programs include the Long Term Home Health Care Program, the Traumatic Brain Injury (TBI) Program,	Covered under Medicaid. Covered by MetroPlusHealth Medicaid. *Limitations may apply.

Benefit	Description of Medicaid Covered Services	MetroPlus Advantage Plan (HMO D-SNP)
	the ICF/MR Waiver, as well as Medicaid Care at Home HCBS Programs and OPWDD Care at Home Programs.	
Medical Social Services	Medical social services include assessing the need for, arranging for and providing aid for social problems related to the maintenance of a patient in the home where such services are performed by a qualified social worker and provided within a plan of care.	Covered under Medicaid. Covered by MetroPlusHealth Medicaid.
Methadone Maintenance Treatment Programs (MMTP)	Medicaid covers MMTP, consisting of drug detoxification, drug dependence counseling, and rehabilitation services which include chemical management with methadone.	Covered under Medicaid. Covered by MetroPlusHealth Medicaid.
Nutrition	Medicaid covers the assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. In addition, these services may include the assessment	Covered under Medicaid. Covered by MetroPlusHealth Medicaid.

Benefit	Description of Medicaid Covered Services	MetroPlus Advantage Plan (HMO D-SNP)
Nutrition (continued)	of nutritional status and food preferences, planning for provision of appropriate dietary intake within the patient's home environment and cultural considerations, nutritional education regarding therapeutic diets as part of the treatment milieu, development of a nutritional treatment plan, regular evaluation and revision of nutritional plans, provision of in-service education to health agency staff as well as consultation on specific dietary problems of patients and nutrition teaching to patients and families. These services must be provided by a qualified nutritionist.	
Office of People with Developmental Disabilities (OPWDD)	Medicaid covers the following OPWDD services: • Long Term Therapy Services Provided by Article16-Clinic Treatment Facilities or Article 28Facilities. • Day Treatment. • Medicaid Service Coordination (MSC). • Home and Community Based Services Waivers (HCBS). • Services Provided Through the Care At Home Program (OPWDD).	Covered under Medicaid. Covered by FFS Medicaid.

Benefit	Description of Medicaid Covered Services	MetroPlus Advantage Plan (HMO D-SNP)
Personal Care Services	Medicaid covers personal care services (PCS), which involve the provision of some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping). Personal care services must be medically necessary, ordered by a physician, and provided by a qualified person in accordance with a plan of care.	Covered under Medicaid. Covered by MetroPlusHealth Medicaid.
Personal Emergency Response Services (PERS) .	Medicaid covers electronic devices which enable certain high-risk patients to secure help in the event of a physical, emotional, or environmental emergency. A variety of electronic alert systems now exist which employ different signaling devices. Such systems are usually connected to a patient's phone and signal a response center once a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted upon by a response center.	Covered under Flex Card benefit. Covered by MetroPlusHealth Medicaid.
Private Duty Nursing	Medicaid covers medically necessary private duty nursing services in accordance with the ordering physician, registered physician assistant or certified nurse practitioner's written treatment plan.	Covered under Medicaid. Covered by MetroPlusHealth Medicaid.

Benefit	Description of Medicaid Covered Services	MetroPlus Advantage Plan (HMO D-SNP)
Rehabilitation Services Provided to Residents of OMH Licensed Community Residence (CRs) and Family Based Treatment Programs	Medicaid covers rehabilitation services provided to residents of the Office of Mental Health (OMH)-licensed community residences (CRs) and family-based treatment programs.	Covered under Medicaid. CRs Covered by FFS Medicaid.
Out-of-Network Family Planning services provided under the direct access provisions of the waiver	Medicaid coverage provided.	Covered under Medicaid Covered by MetroPlusHealth Medicaid.

* Some of the services listed may be covered by Medicaid, however services that include long term care will not be applicable to IB dual members.

SECTION 4 What services are not covered by the plan *OR* Medicare *OR* Medicaid?

Section 4.1 Services *not* covered by the plan *OR* Medicare (exclusions) *OR* Medicaid

This section tells you what services are excluded.

The chart below describes some services and items that aren't covered by the plan *OR* Medicare *OR* Medicaid under any conditions or are covered by the plan OR Medicare *OR* Medicaid only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		• Available for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	**Not covered under any condition.**	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition.**	
Full-time nursing care in your home.	**Not covered under any condition.**	
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.		Post-discharge meals are available, see the Medical Benefits Chart for more information. Homemaker services including basic household assistance, such as light housekeeping or light meal preparation" is a covered **Medicaid benefit** (Personal Care Services).
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition.**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Non-routine dental care.		• Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet.		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease. • Orthopedic shoes or supportive devices for the feet" is a covered Medicaid benefit.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition.**	
Private room in a hospital.		• Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	**Not covered under any condition.**	
Routine chiropractic care.		• Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.	**Not covered under any condition.**	• Routine dental care, such as cleanings, fillings or dentures" is a covered Medicaid benefit
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		• Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. • Routine eye examinations and eyeglasses are covered Medicaid benefits.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine foot care.		• Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Services considered not reasonable and necessary, according to Original Medicare standards.	**Not covered under any condition.**	

CHAPTER 5:
Using the plan's coverage for Part D prescription drugs

How can you get information about your drug costs if you're receiving "Extra Help" with your Part D prescription drug costs?

Most of our members qualify for and are getting "Extra Help" from Medicare to pay for their prescription drug plan costs. If you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the *LIS Rider*. (Phone numbers for Member Services are printed on the back cover of this document.)

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. For additional information on drugs covered by Medicaid, contact the New York State Department of Health Medicaid Program at 888.692.6116 or 718.557.1399.

Section 1.1 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter.) Or, you can fill your prescription through the plan's mail-order service.
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the Drug List for short). (See Section 3 in this chapter.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval before we will cover it. (See Section 4 in this chapter for more information about restrictions on your coverage.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term covered drugs means all of the Part D prescription drugs that are on the plan's Drug List.

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (**metroplusmedicare.org**), and/or call Member Services.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Member Services or use the *Pharmacy Directory*. You can also find information on our website at **metroplusmedicare.org**.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.

- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services.

Section 2.3 Using the plan's mail-order service

For certain kinds of drugs, you can use the plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs that are not available through the plan's mail-order service are marked with an "NM" in our Drug List.

Our plan's mail-order service requires you to order **at least a 30-day supply of the drug and no more than a 90-day supply**.

To get order forms and information about filling your prescriptions by mail, visit our website at **metroplusmedicare.org**.

Usually, a mail-order pharmacy order will be delivered to you in no more than 10 days. If the mail-order pharmacy expects the order to be delayed, they will notify you of the delay. If you need to request a rush order because of a mail-order delay, you may contact Customer Care to discuss options which may include filling at a local retail pharmacy or expediting the shipping method. Provide the representative with your ID number and prescription number(s). If you want second-day or next-day delivery of your medications, you may request this from the Customer Care representative for an additional charge.

New prescriptions the pharmacy receives directly from your doctor's office. After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 5 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by logging in to your **caremark.com** account or by calling Member Services.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

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

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* (**metroplusmedicare.org**) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

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

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Member Services** to see if there is a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- Example 1: You are traveling outside of the service area and you run out of or lose your covered Part D drug(s) or become ill and need a covered Part D drug, and you cannot access a network pharmacy.
- Example 2: You cannot obtain a covered Part D drug in a timely manner within the service area because, for example, there is no network pharmacy within a reasonable driving distance that provides 24-hour-a-day/7-day-per-week service.
- Example 3: You must fill a prescription for a covered Part D drug in a timely manner, and that particular covered Part D drug (for example, a specialty pharmaceutical typically shipped directly from manufacturers or special vendors) is not regularly stocked at accessible network retail or mail-order pharmacies.

- Example 4: You are provided covered Part D drugs dispensed by an out-of-network institution-based pharmacy while you are a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting, and as a result cannot get your medications filled at a network pharmacy.
- Example 5: During any Federal disaster declaration or other public health emergency declaration in which our members are evacuated or otherwise displaced from their place of residence and cannot reasonably be expected to obtain covered Part D drugs at a network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you our share of the cost. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

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

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

The plan has a *List of Covered Drugs (Formulary).* In this *Evidence of Coverage*, **we call it the Drug List for short.**

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

The Drug List includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. Please contact New York State Medicaid Program to determine what excluded drugs may be available to you. You can find phone numbers and contact information for New York State Medicaid in Chapter 2, Section 6.

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

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

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

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

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

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

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Member Services.

What is *not* on the Drug List?

Certain Medicaid-covered drugs are not covered by Medicare drug plans. However, some of these drugs may be covered for you under your Medicaid drug coverage. For additional information on drugs covered by Medicaid, contact the New York State Department of Health Medicaid Program at 888.692.6116 or 718.557.1399.

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs. (For more information about this, see Section 7.1 in this chapter.)
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the Drug List. (For more information, please see Chapter 9.)

Section 3.2 How can you find out if a specific drug is on the Drug List?

You have four ways to find out:

1. Check the most recent Drug List we provided electronically.
2. Visit the plan's website (**metroplusmedicare.org**). The Drug List on the website is always the most current.

3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (**caremark.com** or by calling Member Services). With this tool you can search for drugs on the Drug List to see an estimate of what you will pay and if there are alternative drugs on the Drug List that could treat the same condition. When you register at **caremark.com/welcome-center**, you'll be able to get access to tools and additional resources.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

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

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

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

Restricting brand name drugs when a generic version is available

Generally, a **generic** drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that

treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

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

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

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. **If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.**

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are options:

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

You may be able to get a temporary supply

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

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

- **If you are a new member,** we will cover a temporary supply of your drug during the first ***90 days*** of your membership in the plan**.**
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first ***90 days*** of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than *90 days* and reside in a long-term care facility and need a supply right away:**

  We will cover one *31-day supply* emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

For questions about a temporary supply, call Member Services.

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

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Member Services to ask for a list of covered drugs that

treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

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

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

Section 6.1 The Drug List can change during the year

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

- **Add or remove drugs from the Drug List**.
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

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

See Chapter 12 for definitions of the drug types discussed in this chapter.

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. This section describes the types of changes we may make to the Drug List and when you will get direct notice if changes were made for a drug that you are taking.

Changes we may make to the Drug List that affect you during the current plan year

- **Adding new drugs to the Drug List and <u>immediately</u> removing or making changes to a like drug on the Drug List.**
    - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, add new restrictions, or both. The new version of the drug will be with the same or fewer restrictions.
    - We will make these immediate changes only if we are adding a new generic version of a brand name or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We may make these changes immediately and tell you later, even if you are taking the drug that we are removing or making changes to. If you are taking the like drug at the time we make the change, we will tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
    - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, add new restrictions, or both. The version of the drug that we add will be on the same or fewer restrictions.
    - We will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We will tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you are taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you after we make the change.
- **Making other changes to drugs on the Drug List.**

- We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
- We will tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you are taking.

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

Changes to the Drug List that do not affect you during the current plan year

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

In general, changes that will not affect you during the current plan year are:

- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

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

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

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

Section 7.1 Types of drugs we do not cover

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

If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug is excluded, you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

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

In addition, by law, the following categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. For additional information on drugs covered by Medicaid, contact the New York State Department of Health Medicaid Program at 888.692.6116 or 718.557.1399.

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

If you are receiving "Extra Help" to pay for your prescriptions, the "Extra Help" program will not pay for drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for our share of the costs of your drug. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

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

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

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* (**metroplusmedicare.org**) to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member Services. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

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

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

Special note about creditable coverage:

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

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

Keep this notice about creditable coverage, because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need this notice to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

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

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

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

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

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

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

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

You will not be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

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

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Member Services.

CHAPTER 6:
What you pay for your Part D prescription drugs

How can you get information about your drug costs if you're receiving "Extra Help" with your Part D prescription drug costs?

Most of our members qualify for and are getting "Extra Help" from Medicare to pay for their prescription drug plan costs. If you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the *LIS Rider*.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use **drug** in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs—some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Medicaid.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 5, Section 3.3), the cost shown is provided in "real time," meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real-Time Benefit Tool" by calling Member Services.

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

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called **cost sharing**, and there are three ways you may be asked to pay.

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

Section 1.3 How Medicare calculates your out-of-pocket costs

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

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

<u>Your out-of-pocket costs include</u> the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, employer or union health plans, TRICARE, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $ 2,000 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments <u>are not included</u> in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our plan
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage

- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments for your drugs that are made by the Veterans Health Administration (VA)
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Member Services.

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

- **We will help you**. The *Part D Explanation of Benefits* (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $2,000, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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

Section 2.1 What are the drug payment stages for MetroPlus Advantage Plan (HMO D-SNP) members?

There are three **drug payment stages** for your Medicare Part D prescription drug coverage under MetroPlus Advantage Plan (HMO D-SNP). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 6 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

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

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

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

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

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

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

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Here are examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances
    - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Member Services. Be sure to keep these reports.

SECTION 4 During the Deductible Stage, you pay the full cost of your drugs

Because most of our members get "Extra Help" with their prescription drug costs, the Deductible Stage does not apply to most members. If you receive "Extra Help," this payment stage does not apply to you.

Look at the separate insert (the *LIS Rider*) for information about your deductible amount.

If you do not receive "Extra Help," the Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount, which is $590 for 2025. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines. The **full cost** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid $590 for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

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

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment). Your share of the cost will vary depending on the drug and where you fill your prescription.

Your pharmacy choices

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

- A network retail pharmacy
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Pharmacy Directory* (**metroplusmedicare.org**).

Section 5.2 A table that shows your costs for a one-*month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

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

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Generic drugs (including brand drugs treated as generics)	Depending on your "Extra Help," you pay: -$0 copay or -$1.60 copay or -$4.90 copay	Depending on your "Extra Help," you pay: -$0 copay or -1.60 copay or -$4.90 copay	Depending on your "Extra Help," you pay: -$0 copay or -$1.60 copay or -$4.90 copay	Depending on your "Extra Help," you pay: -$0 copay or -$1.60 copay or -$4.90 copay
All other drugs	Depending on your "Extra Help," you pay: -$0 copay or -$4.80 copay or -$12.15 copay	Depending on your "Extra Help," you pay: -$0 copay or -$4.80 copay or -$12.15 copay	Depending on your "Extra Help," you pay: -$0 copay or -$4.80 copay or -$12.15 copay	Depending on your "Extra Help," you pay: -$0 copay or -$4.80 copay or -$12.15 copay

Please see Section 8 of this chapter for more information on cost sharing for Part D vaccines.

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

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

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

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

you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you receive.

Section 5.4 A table that shows your costs for a *long-term* (90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

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

Tier	Standard retail cost sharing (in-network) (up to a 90-day supply)	Mail-order cost sharing (up to a 90-day supply)
Generic drugs (including brand drugs treated as generics)	Depending on your "Extra Help," you pay: -$0 copay or -$1.60 copay or -$4.90 copay	Depending on your "Extra Help," you pay: -$0 copay or -$1.60 copay or -$4.90 copay
All other drugs	Depending on your "Extra Help," you pay: -$0 copay or -$4.80 copay or -$12.15 copay	Depending on your "Extra Help," you pay: -$0 copay or -$4.80 copay or -$12.15 copay

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,000. You then move on to the Catastrophic Coverage Stage.

The *Part D EOB* that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Not all members will reach the $2,000 out-of-pocket limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 7 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Refer to your plan's Drug List or contact Member Services for coverage and cost-sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

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

Your costs for a Part D vaccination depend on three things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

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

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

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

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

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

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

- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment for the vaccine (including administration).

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

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid.

CHAPTER 7:

Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay for your covered services or drugs

Our network providers bill the plan directly for your covered services and drugs. If you get a bill for the full cost of medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services and drugs should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

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

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid more than your share of the cost for the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly. But sometimes they make mistakes and ask you to pay more than your share of the cost.

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. We do not allow providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

If you were retroactively enrolled in our plan and you paid out of pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the

prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's Drug List or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost of the drug. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within one year** of the date you received the service or item.

You must submit your claim to us within 3 years of the date you received the drug

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster. The required data needed to make a decision includes your name, date of services, the item or service received, and more.
- Either download a copy of the form from our website (**metroplusmedicare.org**) or call Member Services and ask for the form.

To request **payment for medical costs,** mail your request for payment together with any bills or receipts to us at this address:

MetroPlus Health Plan

Complaints Manager
50 Water Street, 7th fl.
New York, NY 10004

To request **payment for drug costs**, mail your request for payment together with any bills or paid receipts to us at this address:

Medicare Part D Paper Claim
P.O. Box 52066
Phoenix, AZ 85072-2066

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

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

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

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost for the service or drug. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost of the care or drug. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

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

CHAPTER 8:
Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

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

Our plan has free interpreter services available to answer questions from non-English speaking members. Written materials are available in languages other than English. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with the plan (phone numbers are printed in the back of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1.800.633.4227) or directly with the Office for Civil Rights 1.800.368.1019 or TTY 1.800.537.7697.

Sección 1.1 Nosotros debemos proporcionar información de una manera que le sirva y que sea coherente con sus sensibilidades culturales (en idiomas distintos del inglés, en braille, en letra grande o en otros formatos alternativos, etc.)

Su plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se provean de una manera culturalmente competente y que estén accesibles para todos los afiliados, inclusive aquellos con un dominio limitado del inglés, habilidades de lectura limitadas, incapacidad auditiva, o aquellos con antecedentes culturales y étnicos diversos. Algunos ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la provisión de servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teletipo).

Nuestro plan cuenta con servicios de intérprete gratuitos para responder las preguntas de los miembros que no hablan inglés. Los materiales escritos se encuentran disponibles en otros idiomas aparte del inglés. También podemos brindarle la información en braille, en letra grande o en otros formatos alternativos sin costo alguno si lo necesita. Estamos obligados a darle información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Por favor, comuníquese con Servicios al Miembro para obtener información que le resulte útil.

Nuestro plan debe proveer a las mujeres inscritas la opción de un acceso directo a un especialista en salud de la mujer dentro de la red para los servicios de atención médica preventiva y de rutina de la mujer.

Si en la red del plan no hay disponibles proveedores para una especialidad, es responsabilidad del plan ubicar proveedores especializados fuera de la red que le brindarán la atención necesaria. En este caso, solo pagará el costo compartido de la red. Si está en una situación en la que no hay especialistas en la red del plan que cubran un servicio que necesita, llame al plan para obtener información sobre dónde ir para obtener este servicio a un costo compartido dentro de la red.

Si tiene problemas para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, para consultar a especialistas en salud de la mujer o para encontrar a un especialista de la red, llame para presentar un reclamo ante el plan (los números de teléfono están impresos en la contratapa de este folleto). También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (800.633.4227) o directamente a la Oficina de Derechos Civiles al 800.368.1019 o al TTY: 800.537.7697.

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

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the **personal information** you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that talks about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other

uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services.

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

As a member of MetroPlus Advantage Plan (HMO D-SNP), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services:

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

service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names

for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the New York State Department of Health:

The New York State Department of Health
Bureau of Managed Care
Certification and Surveillance
Managed Care Complaint Unit
OHIP DHPCO 1CP-1609
Albany, NY 12237-0062
800.206.8125
managedcarecomplaint@health.ny.gov

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we are required to treat you fairly**.

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 or TTY 1.800.537.7697 or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:You can **call Member Services**.

- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or **you can call Medicare** at 1-800-MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week (TTY 1.877.486.2048).

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections*. (The publication is available at: **medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**)
  - Or, you can call 1-800-MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week (TTY 1.877.486.2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services.
    - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
    - You must pay your plan premiums.
    - You must continue to pay your Medicare premiums to remain a member of the plan.
    - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
    - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage

  - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.

- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9:

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

SECTION 1 Introduction

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

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you would like help deciding whether to use the Medicare process or the Medicaid process, or both, please contact Member Services.

2. The type of problem you are having:
    - For some problems, you need to use the **process for coverage decisions and appeals**.
    - For other problems, you need to use the **process for making complaints;** also called grievances.

These processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says making a complaint rather than filing a grievance, coverage decision rather than organization determination or coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful—and sometimes quite important—for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.
- You can also visit the Medicare website (**medicare.gov**).

You can get help and information from Medicaid

- For more information and help in handling a problem, you can also contact New York State Medicaid. To get information directly from Medicaid, you can call the New York State Department of Health Medicaid Program at 800.505.5678 (TTY: 888.329.1541). You can also visit the New York Medicaid website (**health.ny.gov/health_care/managed_care/**).

SECTION 3 To deal with your problem, which process should you use?

Because you have Medicare and get assistance from Medicaid, you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Medicaid, then you should use the Medicaid process. If you would like help deciding whether to use the Medicare process or the Medicaid process, please contact Member Services.

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

Is your problem about Medicare benefits or Medicaid benefits?

If you would like help deciding whether your problem is about Medicare benefits or Medicaid benefits, please contact Member Services.

My problem is about **Medicare** benefits.

> Go to the next section of this chapter, **Section 4, Handling problems about your Medicare benefits.**

My problem is about **Medicaid** coverage.

> Skip ahead to **Section 12** of this chapter, **Handling problems about your Medicaid benefits.**

PROBLEMS ABOUT YOUR MEDICARE BENEFITS

SECTION 4 Handling problems about your Medicare benefits

Section 4.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare**.

To figure out which part of this chapter will help with your problem or concern about your **Medicare** benefits, use this chart:

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

Yes.

Go on to the next section of this chapter, **Section 5, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 11** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B prescription drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied, whether before or after a benefit is received, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 7 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 10 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 5.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at **cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.)
    - For medical care, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.

  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your **representative** to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at **cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3 Which section of this chapter gives the details for your situation?

There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter: Your medical care: How to ask for a coverage decision or make an appeal
- **Section 7** of this chapter: Your Part D prescription drugs: How to ask for a coverage decision or make an appeal
- **Section 8** of this chapter: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon
- **Section 9** of this chapter: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Member Services. You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 6.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

   Note: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Section 6.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **organization determination.** A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 14 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines
    - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision
    - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 11 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a fast complaint. (See Section 11 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 6.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We are allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal, and we give you our answer.

- When we are reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
    - **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service**.** If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 11 of this chapter for information on complaints.)
    - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.

If our plan says no to part or all of your appeal, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 6.4 Step-by-step: How a Level 2 appeal is done

Legal Term
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

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

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

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

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

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you about its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage **within 72 hours** or provide the service within **14 calendar days** after we receive the independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date the plan receives the independent review organization's decision for **expedited requests**.
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Medicare Part B prescription drug **within 72 hours** after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests.**
- **If this organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter:
    - Explaining its decision.
    - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage you are requesting meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
    - Telling you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 in this chapter explains the Levels 3, 4, and 5 appeals processes.

Section 6.5 What if you are asking us to pay you back for our share of a bill you have received for medical care?

We can't reimburse you directly for a Medicaid service or item. If you get a bill that is more than your copay for Medicaid-covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. But if

you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting the service or item.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 6.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we

generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or *Formulary.*

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 7.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get) **Ask for an exception. Section 7.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception.** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to all of our drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review of our decision by making an appeal.

Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

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

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
    - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* which is available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the supporting statement,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
    - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
    - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 7.5 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.** A fast appeal is also called an **expedited redetermination.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal.**

- **For standard appeals, submit a written request** or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** (at 866.986.0356 (TTY: 711), Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website **metroplusmedicare.org.** Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal. **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 7.6 Step-by-step: How to make a Level 2 appeal

Legal Term
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

- ***For fast appeals:***
  - **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

- ***For standard appeals:***
  - **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It is also called **turning down your appeal**.). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two calendar days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Services or 1-800-MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. (TTY 1.877.486.2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two calendar days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call

877.486.2048. You can also see the notice online at **cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices**.

Section 8.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline,** you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the Detailed Notice of Discharge by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at **cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices**.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to **Level 2** of the appeals process.

Section 8.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 9.2 We will tell you in advance when your coverage will be ending

Legal Term
Notice of Medicare Non-Coverage. It tells you how you can request a **fast-track appeal.** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.

- How to request a fast-track appeal to request us to keep covering your care for a longer period of time.

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan's decision to stop care.

Section 9.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

<u>Step 1:</u> Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.)

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline for contacting the Quality Improvement Organization, you may still have appeal rights. Contact the Quality Improvement Organization.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 9.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You could ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over**. Unlike a decision at Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal:	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
    - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal	A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or attorney adjudicator who works for the Federal** government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal	A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms

- A **Complaint** is also called a **grievance.**
- **Making a complaint** is also called **filing a grievance.**
- **Using the process for complaints** is also called **using the process for filing a grievance.**
- A **fast complaint** is also called an **expedited grievance.**

Section 11.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

MetroPlus Health Plan's Grievance Department is available to help you. You can file a grievance by mail, or by fax. If you have a complaint, please contact Member Services at:

MetroPlus Health Plan
Attn: Medicare Complaints Manager
50 Water Street, 7th fl.
New York, NY 10004
Phone: 866.986.0356
Fax: 212.908.3011

We will try to resolve your complaint over the phone or within 24 hours of receipt of the complaint.

- You may file a complaint about the amount of time we take to make a coverage determination or organization determination (also called coverage decisions). For example, if we extended the timeframe for reaching a coverage decision or we denied your request to grant an expedited (fast) coverage decision. For these types of issues, you can file an expedited (fast) compliant by **calling Member Services**. We will try to resolve your complaint within 24 hours of receipt.

- You can file this complaint yourself, or have an authorized representative file the complaint for you. To appoint an authorized representative, submit the "Appointment of Representative" form, located on our website at **metroplusmedicare.org**.

The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 11.5 You can also tell Medicare about your complaint

You can submit a complaint about MetroPlus Advantage Plan (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to **medicare.gov/MedicareComplaintForm/home.aspx**. You may also call 1-800-MEDICARE (800.633.4227). TTY/TDD users can call 877.486.2048.

PROBLEMS ABOUT YOUR MEDICAID BENEFITS

SECTION 12 Handling problems about your Medicaid benefits

Consumers have a right to an external appeal when their HMO or insurer (health plan) denies health care services as **not medically necessary (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit), experimental / investigational (including a clinical trial or rare disease treatment) or, in certain cases, out-of-network**. To request an external appeal, consumers or their designees must complete the New York State External Appeal Application and send it to the New York State Department of Financial Services within four (4) months of the date of the health plan's final adverse determination. Providers have their own right to an external appeal when health care services are denied concurrently or retrospectively and must request an external appeal within 60 days. To access the application, go to **dfs.ny.gov/complaints/file_external_appeal**.

What is an external appeal? It is a request you make to the Department of Financial Services when a health plan denies health care services. Your appeal will be reviewed by an independent external appeal agent with medical experts that will either overturn (in whole or part), or uphold the health plan's denial.

When do I request an external appeal? Consumers or their designees must send an external appeal application to the Department of Financial Services within four (4) months from the date of the final adverse determination from the first level of appeal with the health plan or the waiver of the internal appeal process. Providers appealing on their own behalf must request an external appeal within 60 days of the final adverse determination. If you do not send your application to the Department of Financial Services within the required timeframe (with an additional eight (8) days allowed for mailing), you will not be eligible for an external appeal. For more information, please contact the New York State Department of Financial Services at 800.400.8882.

What if services are denied as experimental/investigational (including a clinical trial or rare disease)? The patient's physician (for rare diseases cannot be the treating physician) must complete and send pages 4-6 of the application to the Department of Financial Services.

What if services are denied as out-of-network? The patient must have an HMO or managed care insurance contract and a pre-authorization request must be denied because the service is not available in-network and the health plan recommends an alternate in-network service that it believes is not materially different from the out-of- network service. The patient's physician must complete and send pages 4-7 of the application to the Department of Financial Services.

When will an external appeal agent make a decision? Within **72 hours** for expedited appeals or **30 days** for standard appeals. The external appeal agent's decision is binding on the patient and the patient's health plan.

How do I request an expedited (fast-tracked) external appeal? The denial must concern an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized; or the patient's physician must complete pages 4-6 of the application and attest that the patient has not received the treatment and a 30-day timeframe would seriously jeopardize the patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to the patient's health. The patient may request an expedited internal and external appeal at the same time. Once an external appeal is expedited, a decision will be made in 72 hours, even if all the patient's medical information has not been submitted.

When can I send information to the external appeal agent? You will be notified when an external appeal agent is assigned. You must send any information to the agent **immediately**. Once the agent makes a decision, additional information will not be considered.

Do I pay a fee for an external appeal? Health plans may charge a $25.00 fee to patients or their designees, not to exceed $75.00 in a single plan year. The fee is waived for patients who appeal and are covered under Medicaid, HIV SNP or HARP, or if the fee will pose a hardship. Health plans may charge providers a $50.00 fee per appeal. The fee will be returned to you if the external appeal agent overturns the health plan's denial.

What if a patient has Medicare or Medicaid coverage? Patients covered under Medicare are not eligible for a NYS external appeal and should call 1-800-MEDICARE or visit **Medicare.gov**. Patients covered under regular Medicaid are not eligible for an external appeal; however, patients covered under a Medicaid Managed Care Plan are eligible. All Medicaid patients may also request a fair hearing, and the fair hearing decision will be the one that applies. Call 800.342.3334 or visit **otda.state.ny.us/oah** for fair hearing information.

FOR QUESTIONS OR HELP WITH AN APPLICATION, CALL THE NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES AT 800.400.8882, or E-MAIL at **externalappealquestions@dfs.ny.gov**, OR VISIT **dfs.ny.gov**. If you are faxing an expedited appeal, call 888.990.3991.

Section 12.1 Instructions for IB dual enrollees

For questions or help with **appeals and grievances**, IB dual enrollees can call MetroPlus Advantage Plan (HMO D-SNP) directly. Call our Member Services number at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free.

IB dual enrollees can submit a complaint about MetroPlus Advantage Plan (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to **medicare.gov/MedicareComplaintForm/home.aspx**. You may also call 1-800-MEDICARE (800.633.4227). TTY/TDD users can call 877.486.2048.

IB dual enrollees can submit a complaint about MetroPlus Advantage Plan (HMO D-SNP) directly to Medicaid. To submit a complaint to Medicaid, call 800.206.8125, or email **managedcarecomplaint@health.ny.gov**.

Plan Appeals

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization request**. This process is described earlier in this handbook. The notice of our decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **Initial Adverse Determination**.

If you are not satisfied with our decision about your care, there are steps you can take.

Your provider can ask for reconsideration:

If we made a decision that your service authorization request was not medically necessary, or was experimental or investigational, and we did not talk to your doctor about it, your doctor may ask to speak with our Medical Director. The Medical Director will talk to your doctor within one work day.

You can file a Plan Appeal:

If you think our decision about your service authorization request is wrong, you can ask us to look at your case again. This is called a **Plan Appeal**.

- You have **60 calendar days** from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services at 866.986.0356 if you need help asking for a Plan Appeal or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor, or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.

- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal

Aid to continue while appealing a decision about your care:

If we decided to reduce, suspend, or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided. You must ask for your Plan Appeal:

- **Within 10 days from being told that your care is changing; or**
- **By the date the change in services is scheduled to occur, whichever is later.**

If your Plan Appeal results in another denial, you may have to pay for the cost of any continued benefits that you received.

You can call or write to ask for a Plan Appeal. When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters, or other information that explains why you need the service.
- Any specific information we said we needed in the *Initial Adverse Determination* notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records, and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling 800.303.9626.

Give us your information and materials by phone, fax, or mail:

Phone.....	866.986.0356
Fax.....	212.908.8824
Mail.....	Appeals Coordinator MetroPlus Health Plan 50 Water Street New York, NY 10004

If you ask for a standard Plan Appeal orally, you will also need to ask for it in writing. (You won't have to do this for an expedited Plan Appeal.) When you file a standard Plan Appeal orally, we have to tell you that you need to ask us in writing too. We may choose to send you a summary of the Plan Appeal. You will need to sign and return the summary.

If we get an appeal request from you orally, we will send you a letter with a summary of the appeal. The letter will also give you the option to review and change your request.

If you are asking for an out-of-network service or provider:

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:
    1. a statement in writing from your doctor that the out-of-network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board-certified or board-eligible specialist who treats people who need the service you are asking for.
    2. two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

    If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. *See the External Appeal section later in this handbook.*

- If you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out-of-network provider. You will need to ask your doctor to send this information with your appeal:
    1. a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
    2. a recommendation to an out-of-network provider with the correct training and experience who is able to provide the service.

    Your doctor must be a board-certified or board-eligible specialist who treats people who need the service you are asking for. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. *See the External Appeal section later in this handbook.*

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.

- You can also provide information to be used in making the decision in person or in writing. Call MetroPlusHealth at 866.986.0356 if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination**.
- **If you think our Final Adverse Determination is wrong:**
    - You can ask for a Fair Hearing. *See the Fair Hearing section below.*
    - For some decisions, you may be able to ask for an External Appeal. *See the External Appeal section of this handbook.*
    - You may file a complaint with the New York State Department of Health at 800.206.8125.

Timeframes for Plan Appeals:

- **Standard Plan Appeals:** If we have all the information we need, we will tell you our decision within 30 calendar days from when you asked for your Plan Appeal.
- **Fast-track Plan Appeals:** If we have all the information we need, fast-track Plan Appeal decisions will be made in 2 working days from your Plan Appeal, but not more than 72 hours from when you asked for your Plan Appeal.
    - We will tell you within 72 hours if we need more information.
    - If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
    - We will tell you our decision by phone and send a written notice later.

Your Plan Appeal will be reviewed under the fast-track process if:

- you or your doctor asks to have your Plan Appeal reviewed under the fast-track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your Plan Appeal will be reviewed under the standard process; **or**
- your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; **or**
- your request was denied when you asked for home health care after you were in the hospital; or
- your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

If we need more information to make either a standard or fast-track decision about your Plan Appeal, we will:

- Write you and tell you what information is needed. If your request is in a fast-track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest; and
- Make a decision no later than 14 days from the day we asked for more information.

You or your representative may also ask us to take more time to make a decision. This may be because you have more information to give MetroPlusHealth to help decide your case. This can be done by calling 800.303.9626, or by writing.

You or your representative can file a complaint with MetroPlusHealth if you don't agree with our decision to take more time to review your Plan Appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 800.206.8125.

If you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. *See the Fair Hearing section below.*

The original denial will be reversed and your service authorization request will be approved if we do not decide your Plan Appeal on time, and we said the service you are asking for is:

1. not medically necessary, or
2. experimental or investigational, or
3. not different from care you can get in the plan's network, or
4. available from a participating provider who has the correct training and experience to meet your needs.

External Appeals

You have other appeal rights if the service you are asking for was:

1. not medically necessary
2. experimental or investigational
3. not different from care you can get in the plan's network
4. available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, you can ask New York State (NYS) for an independent **External Appeal**. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or NYS. These reviewers are qualified people approved by NYS. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; **or**
- If you have not gotten the service, and you ask for a fast-track Plan Appeal, you may ask for an expedited External Appeal at the same time. Your doctor will have to say an expedited External Appeal is necessary; **or**
- You and MetroPlusHealth may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove MetroPlusHealth did not follow the rules correctly when processing your Plan Appeal.

You have **4 months** after you receive MetroPlusHealth's Final Adverse Determination to ask for an External Appeal. If you and MetroPlusHealth agreed to skip our appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at 866.986.0356 if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services at 800.400.8882.
- Go to the Department of Financial Services' website at **dfs.ny.gov/**.
- Contact MetroPlusHealth at 800.303.9626.

Your External Appeal will be decided in 30 days. More time (up to five working days) may be needed if the External Appeal reviewer asks for more information. You and MetroPlusHealth will be told the final decision within two days after the decision is made.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health; or
- You are in the hospital after an emergency room visit and the hospital care is denied by your plan.

This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:

- you ask for a fast-track Plan Appeal within 24 hours, **AND**
- you ask for a fast-track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast-track Plan Appeal in 24 hours. The fast-track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends, or stops your service, you can ask for a Fair Hearing. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

Fair Hearings

You may ask for a Fair Hearing from New York State if:

- You are not happy with a decision your Local Department of Social Services or the State Department of Health made about your staying with or leaving MetroPlusHealth.

- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the *Notice of Intent to Restrict* to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the *Notice of Intent to Restrict*, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.

- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with MetroPlusHealth. If we agree with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.

- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
    - reduce, suspend, or stop care you were getting; or
    - deny care you wanted; or
    - deny payment for care you received; or
    - not let you dispute a copay amount, other amount you owe, or payment you made for your health care.

You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will then have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

- **If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you are getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a fair hearing within 10 days from the date of the Final Adverse Determination, or by the time the action takes effect, whichever is later.** However, if you choose to ask for services to be continued, and you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.

The decision you receive from the fair hearing officer will be final.

You can use one of the following ways to request a Fair Hearing:

1. By phone — call toll-free: 800.342.3334
2. By fax — 518.473.6735
3. By internet — **otda.state.ny.us/oah/forms.asp**
4. By mail — New York State Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   Managed Care Hearing Unit
   P.O. Box 22023
   Albany, NY 12201-2023
5. In person: — For non-New York City residents:

   Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   40 North Pearl Street
   Albany, NY 12243

   For New York City residents:

   Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   5 Beaver Street
   New York, NY 10004

When you ask for a Fair Hearing about a decision MetroPlusHealth made, we must send you a copy of the **evidence packet.** This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you.

If you do not get your evidence packet by the week before your hearing, you can call 866.986.0356 to ask for it.

Remember, you may complain anytime to the New York State Department of Health by calling 800.206.8125.

CHAPTER 10:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in MetroPlus Advantage Plan (HMO D-SNP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

- Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:
    - Original Medicare *with* a separate Medicare prescription drug plan,
    - Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
    - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

    Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

    Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this document).
- Other Medicare health plan options are available during the **Annual Enrollment Period**. Section 2.2 tells you more about the Annual Enrollment Period.
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the Annual Open Enrollment Period). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare health plan, with or without prescription drug coverage.
    - Original Medicare *with* a separate Medicare prescription drug plan

      OR

    - Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
    - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
    - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.

- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (**medicare.gov**):

- Usually, when you have moved.
- If you have Medicaid.
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.
- **Note:** Section 2.1 tells you more about the special enrollment period for people with Medicaid.

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users call 1.877.486.2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage,
- Original Medicare *with* a separate Medicare prescription drug plan,
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and "Extra Help".

Section 2.5 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Member Services.**
- Find the information in the ***Medicare & You 2025*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. (TTY 1.877.486.2048)

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan	• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from MetroPlus Advantage Plan (HMO D-SNP) when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from MetroPlus Advantage Plan (HMO D-SNP) when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan o If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. o If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.	• **Send us a written request to disenroll** Contact Member Services if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1.877.486.2048. • You will be disenrolled from MetroPlus Advantage Plan (HMO D-SNP) when your coverage in Original Medicare begins.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your New York State Medicaid benefits, contact the New York State Department of Health Medicaid Program at 888.692.6116 or 718.557.1399; Monday through Friday, 8am to 5pm. Ask how joining another plan or returning to Original Medicare affects how you get your New York State Medicaid coverage.

SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership MetroPlus Advantage Plan (HMO D-SNP) ends, and your new Medicare and Medicaid coverage begins, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 MetroPlus Advantage Plan (HMO D-SNP) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

MetroPlus Advantage Plan (HMO D-SNP) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you are no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. We will assist you with enrolling in another plan for which you are eligible.
- If you do not pay your medical spenddown, if applicable
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.

- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 90 days.
    - We must notify you in writing that you have 90 days to pay the plan premium before we end your membership
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, call Member Services.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

MetroPlus Advantage Plan (HMO D-SNP) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1.800.633.4227) 24 hours a day, 7 days a week (TTY 1.877.486.2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 800.368.1019 (TTY: 800.537.7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at **hhs.gov/ocr/index.html**.

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, MetroPlus Advantage Plan (HMO D-SNP), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

✓MetroPlusHealth

MetroPlus Health Plan Annual Privacy Notice

MetroPlusHealth respects your privacy rights. This notice describes how we treat the nonpublic personal financial and health information ("Information") we receive about you and what we do to keep it confidential and secure as required by New York State Insurance Law (Regulation 169).

In addition, you can request a full text version of MetroPlusHealth's **Notice of Health Information Privacy Practices**, which describes how medical information about you may be used and disclosed under the Federal Health Insurance Portability and Accountability Act (HIPAA) at any time by contacting the MetroPlusHealth Privacy Officer. This information is also available on our website at www.metroplus.org/privacy-policies

Types of Information

MetroPlusHealth collects Information about you from the following sources and may disclose:	• Information you give us on application and other forms or that you tell us; and • Information about your dealings with us, the health care providers we work with, and others.
What we do with your information: **We do not disclose Information about our members and former members to anyone, except as permitted by law.**	• To provide the health care benefits you receive as a member of MetroPlusHealth, for example, to arrange for treatment that you need and to pay for services you receive; • To communicate with you about programs and services that are available to you as a MetroPlusHealth member; and • To manage our business and comply with legal and regulatory requirements.

How we protect your privacy	• We limit access to your Information to employees and other persons who need it to conduct MetroPlusHealth business or comply with legal and regulatory requirements. • Employees are subject to discipline, and may be fired, if they violate our privacy policies and procedures. • We also use physical, electronic and procedural safeguards to keep Information confidential and secure in accordance with state and federal regulations.
Former Members	• If your membership with MetroPlusHealth ends, your Information will remain protected in accordance with our policies and procedures for current members.
Contact MetroPlus	• Request more information about our privacy policies and practices, • File a privacy-related complaint with us, or • Request (in writing) to review Information about you in our records. **Customer Services – MetroPlus Health Plan** **50 Water Street, 7th Floor** **New York, NY 10004** • **General Phone:** 1.800.303.9626, 7 days per week 8am to 8pm • **Medicare Members:** 1.866.986.0356, 7 days per week, 8pm to 8pm • **TTY:** 711 • **E-mail:** PrivacyOfficer@metroplus.org

Your Information.

Your Rights.

Our Responsibilities.

MetroPlus Health Plan
50 Water Street, 7th Floor
New York, NY 10004
Website: metroplus.org
General Phone: 800.303.9626
TTY: 711
E-mail: PrivacyOfficer@metroplus.org

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We will charge you $0.75 (75 cents) for each page of copies you request.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say “no” to your request, but we will tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

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Your Rights (continued)

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. • To ask for confidential communications, call our Member Services Department at 1-800-303-9626 (TTY: 711). Requests to change or modify this type of confidential communication request must be made in writing to the address listed below.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. You may get a paper copy of this notice at any time by calling our Member Services Department at 1.866.986.0356(TTY: 711).
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

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Your Rights (continued)

Former Members	• If your membership with MetroPlusHealth ends, your Information will remain protected in accordance with our policies and procedures for current members.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care. • Share information in a disaster relief situation If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you. • Health Related Products or Programs: MetroPlusHealth may provide you information on medical treatments, programs products and services.	**Example**: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

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Our Uses and Disclosures (continued)

	The information provided to you is subject to any limits imposed by the law. • Reminders: MetroPlusHealth may use and disclose PHI about you (for example, by calling or texting you or sending you a letter) to remind you of an appointment for treatment or that it's time for you to schedule an appointment for a regular check-up or immunization, or to provide information about treatment alternatives ("choices") or other health-related benefits and services that may be of interest to you.	
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	**Example:** We use health information about you to develop better services for you. MetroPlusHealth's Quality Management Department may use your health information to help improve the quality of the Plan's programs, data and business processes. As an example, your medical record may be reviewed by our quality management staff or contracted nurse reviewers to evaluate the quality of care provided to you and all Plan members.

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Our Uses and Disclosures (continued)

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Administer your plan	We may disclose your health information to your health plan sponsor for plan administration.	**Example:** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.
Pay for your health services	We can use and disclose your health information as we pay for your health services.	**Example:** We share information about you with your dental plan to coordinate payment for your dental work.
Provide quality care and efficient delivery of services	MetroPlusHealth participates in the health information exchange operated by Healthix. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. This Notice is to inform our patients that as part of participation in Healthix, MetroPlusHealth electronically sends/uploads our patients' Protected Health Information to Healthix. Additionally, certain staff at MetroPlusHealth are authorized to access patient information through Healthix subject to applicable consent rules. Consent to access Healthix is normally granted on an organization-by-organization basis. However, patients have the option of denying access to all organizations in Healthix. If you are interested in denying consent for all Healthix organizations to access your Protected Health Information, you may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877.695.4749. Information in Healthix about patients comes from places that have provided medical care or through health insurance (claims) information. These data sources may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program and other organizations that exchange health information electronically. An updated list of these data sources is available from Healthix. Patients can obtain an updated list at any time by visiting www.healthix.org or by calling 1.877.695.4749.	

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Our Uses and Disclosures (continued)

Help with public health and safety issues	We can share health information about you for certain situations such as: o Preventing disease o Reporting adverse reactions to medications o Reporting suspected abuse, neglect, or domestic violence o Preventing or reducing a serious threat to anyone's health or safety.
Perform Research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: o For worker's compensation claims o For law enforcement purposes or with a law enforcement official o With health oversight agencies authorized by law o For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal action	We can share health information about you in response to a court or **legal** administrative order, or in response to a subpoena
New York State laws on disclosures for certain types of information	MetroPlusHealth must comply with additional New York State laws that have a higher level of protection for personal information, particularly information relating to HIV/AIDS status or treatment; mental health; substance use disorder; and family planning.

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Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This notice is effective as of July 19, 2022.

Privacy Officer Contact Information

If you have questions about our privacy practices, or if you want to file a complaint or exercise rights described above, please contact:

Customer Services – MetroPlus Health Plan
50 Water Street, 7th Floor
New York, NY 10004

- **General Phone:** 1.800.303.9626, 7 days per week 8am to 8:00pm
- **Medicare Members:** 1.866.986.0356, 7 days per week, 8:00am to 8pm
- **TTY:** 711
- **E-mail:** PrivacyOfficer@metroplus.org

✓MetroPlusHealth

MULTI-LANGUAGE INSERT |

MULTI-LANGUAGE INTERPRETER SERVICES

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 866.986.0356. Someone who speaks English and other languages can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 866.986.0356. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 866.986.0356。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 866.986.0356。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 866.986.0356. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 866.986.0356. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 866.986.0356 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 866.986.0356. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 866.986.0356 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 866.986.0356. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 866.986.0356. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 866.986.0356 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 866.986.0356. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 866.986.0356. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 866.986.0356. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 866.986.0356. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、
866.986.0356 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

CHAPTER 12:
Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of MetroPlus Advantage Plan (HMO D-SNP), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period –The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (See "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,000 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles.

Complaint — The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. This is in addition to the plan's monthly premium .Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called coverage decisions in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – A type of plan that enrolls individuals who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the individual's eligibility.

Dually Eligible Individuals – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a generic drug

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Integrated D-SNP – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are also known as full-benefit dually eligible individuals.

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) –A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets

additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (Formulary or Drug List) – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.)

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Pharmacy –A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (**Traditional Medicare or Fee-for-Service Medicare**) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose "Extra Help", you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) –The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization –Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics –Medical devices including, but not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing

conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

MetroPlus Advantage Plan (HMO D-SNP) Member Services

Method	Member Services – Contact Information
CALL	866.986.0356 Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free
FAX	212.908.5196
WRITE	MetroPlus Health Plan 50 Water Street, 7th fl. New York, NY 10004 Attn: Medicare Department
WEBSITE	**metroplusmedicare.org**

Health Insurance Information, Counseling and Assistance Program (HIICAP) (New York's SHIP)

Health Insurance Information, Counseling and Assistance Program (HIICAP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1.800.701.0501
TTY	New York City Department for the Aging 2 Lafayette Street, 9th fl. New York, NY 10007-1392
WEBSITE	**nyconnects.ny.gov**

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

✓MetroPlusHealth

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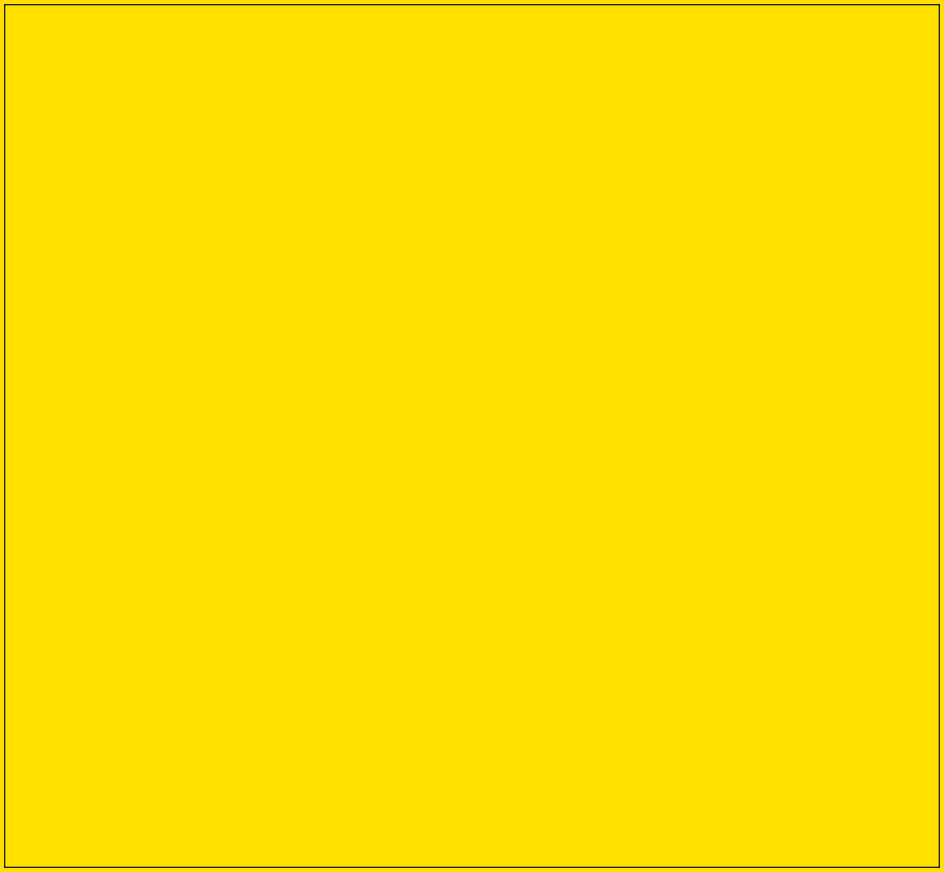

METROPLUSMEDICARE.ORG

PLEASE CALL OUR 24/7 HELP LINE AT 866.986.0356 (TTY: 711) AND A REPRESENTATIVE WILL ASSIST YOU.

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