

2027

METROPLUS ULTRACARE (HMO D-SNP)

EVIDENCE OF COVERAGE (EOC)



January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services and Drug coverage as a Member of MetroPlus UltraCare (HMO D-SNP)

This document gives the details of your Medicare and New York State Medicaid Program health and drug coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

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

For questions about this document, call Member Services at 866.986.0356. (TTY users 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 UltraCare (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. When it says “plan” or “our plan,” it means MetroPlus UltraCare (HMO D-SNP).

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

- MetroPlus Health Plan, Inc. offers HMO and HMO D-SNP plans with contracts with Medicare and the New York State Medicaid Program. Enrollment in MetroPlus Health Plan, Inc. depends on contract renewal.
- MetroPlusHealth is not affiliated with, endorsed by, or otherwise related to the federal government, CMS, HHS, and/or Medicare. MetroPlus Health Plan, Inc. complies with applicable federal civil rights laws and MetroPlusHealth does not discriminate on the

basis of race, color, national origin, sex, age, or disability in its health programs and activities.

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de Asistencia lingüística. Llame al 866.986.0356 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 866.986.0356 (TTY: 711)
- MetroPlus UltraCare (HMO D-SNP) is a Medicaid Advantage Plus (MAP) Plan for people who qualify for both Medicare and Full Medicaid benefits, and who need coordinated long-term community-based services in a home setting. This plan will cover most of your Medicare and Medicaid benefits.
- 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 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 State Medicaid Choice at 800.541.2831 if you need interpreter services or OMB Approval 0938-1051 (Expires: August 31, 2026) 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 USERS CALL 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 USERS CALL 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](https://www.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 USERS CALL 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.

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of MetroPlus UltraCare (HMO D-SNP)

Section 1.1 You're enrolled in MetroPlus UltraCare (HMO D-SNP), which is a Medicare Special Needs Plan

You're covered by both Medicare and Medicaid:

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

You've chosen to get your Medicare health care and your drug coverage through our plan, MetroPlus UltraCare (HMO D-SNP). Our plan covers all Part A and Part B services. However, cost sharing and provider access in our plan differ from Original Medicare.

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

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

MetroPlus UltraCare (HMO D-SNP) is run by a non-profit organization. Like all Medicare UltraCares, this Medicare Special Needs Plan is approved by Medicare. Our plan also has a

Chapter 1 Get started as a member

contract with the New York Medicaid program to coordinate your Medicaid benefits. We're pleased to provide your Medicare coverage, and Medicaid coverage, long-term care, home and community-based services including drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how MetroPlus UltraCare (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 get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in MetroPlus UltraCare (HMO D-SNP) between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of MetroPlus UltraCare (HMO D-SNP) after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.3). People who are incarcerated aren't considered to be living in the geographic service area even if they're physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.
- You meet the special eligibility requirements described below.

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Special eligibility requirements for our plan

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

In addition, you must:

1. Be 18 years of age or older;
2. Reside in our plan's service area which is the Bronx, Brooklyn, Manhattan, Queens, and Staten Island;
3. Be eligible for nursing home level of care (as of the time of enrollment) using the Uniform Assessment System (UAS) or other tool designated by SDOH;
4. Be capable, at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, based upon criteria provided by SDOH;

and

5. Need at least one (1) of the following community-based long-term care services for more than 120 days from the effective date of enrollment:
 - Nursing services in the home
 - Therapies in the home
 - Home health aide services
 - Personal care services in the home
 - Adult day health care
 - Private Duty Nursing, or

Consumer Directed Personal Assistance Services

6. Are capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, or you are permanently placed in a nursing home.
7. Need at least one CBLTSS for more than 120 days and the following:
 - individuals with a diagnosis by a physician of Dementia or Alzheimer's and need help with at least supervision with more than one activity of daily living (ADL); or

Chapter 1 Get started as a member

- individuals who are assessed as needing at least limited assistance with physical maneuvering with more than two ADLs

CBLTSS includes services provided in the home or community setting (any place of residence, either permanent or temporary, other than a hospital, skilled nursing home, or health related facility) as included in the MAP plan benefit package and provided by the MAP plan when medically necessary. CBLTSS services include Private Duty Nursing, Skilled Nursing, Home Health Services, Personal Care Services, Consumer Directed Personal Assistance Services, and Adult Day Health Care.

Note: If you lose your New York State Medicaid eligibility but can reasonably be expected to regain eligibility within three (3) month(s), then you're still eligible for membership. Chapter 4, Section 2.1 tells you about coverage and cost sharing during this period.

Section 2.2 Medicaid

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

In addition, Medicaid offers programs to help people pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary Plus (QMB+):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments) plus full Medicaid benefits.
- **Full Benefit Dual Eligible (FBDE):** Helps pay Medicare Part B premiums in some cases, Medicare Part A premiums, and full Medicaid benefits.

Section 2.3 Plan service area for MetroPlus UltraCare (HMO D-SNP)

MetroPlus UltraCare (HMO D-SNP) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our 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 to a new state, you should also contact your state's Medicaid office and ask how this move will affect your Medicaid benefits. Phone numbers for Medicaid are in Chapter 2, Section 6 of this document.

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If you move out of our plan's service area, you can't stay a member of this plan. Call 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), to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 800.772.1213 (TTY users call 800.325.0778).

Section 2.4 U.S. citizen or national, or eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify MetroPlus UltraCare (HMO D-SNP) if you're not eligible to stay a member of our plan on this basis. MetroPlus UltraCare (HMO D-SNP) must disenroll you if you don't meet this requirement.

SECTION 3 What to expect when you first join our plan

Section 3.1 Health risk assessment

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date. Upon enrollment into MetroPlus DSNP plan an HRA is administered within 90 days from your enrollment effective date.

We must complete an HRA for you. The HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs and Social Determinants of Health.

We'll reach out to you to complete the HRA. MetroPlus will attempt to make a minimum of 3 non-automated telephonic outreach calls to solicit an HRA for D-SNP members. An Unable to Reach (UTR) letter is also sent to non-respondents. In addition to telephonic outreach, the QM Department may also seek to complete an HRA for SNP members through electronic sources such as a text message or a nanosite, a temporary mini website tailored for mobile phones. We'll send you more information about this HRA. We'll then contact you annually for any updates to determine if your needs have changed.

Section 3.2 Care team and care plan

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, specialists you see, or other health professionals that you choose.

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You work with a care team to make a care plan based on your preferences. A care plan tells you and your doctors and other health providers what services you need and how to get them. It includes your medical, behavioral health, and if applicable long-term services and supports, social services, community-based services, or other services if needed.

Your individualized care plan is developed with you with input from your primary care provider and may include your caregiver or authorized representative if you choose. The care plan is based on information from your health assessment, medical history, claims and utilization data, pharmacy information, and your individual needs and preferences. It is person-centered and designed to address your medical, behavioral health, functional, social, and LTSS needs. The care plan is reviewed at least annually and updated whenever there is a significant change in your health status, care needs, or after a transition of care, such as a hospitalization. The care team works together to monitor your progress, address barriers to meeting goals, and revise interventions as needed.

Your individualized care plan may include the following, as applicable:

- your health care goals as prioritized by you;
- your health conditions, medications, and any ongoing treatments;
- services and supports needed to meet your medical, behavioral health, social, and LTSS needs;
- interventions and measurable outcomes designed to help you achieve your goals;
- your preferences, strengths, expectations, and support network;
- plans for care transitions, coordination among providers, and access to community resources; and
- identification of potential barriers to achieving your goals and strategies to address them a timeline for getting the services you need.

Your care manager contacts you after your Health Risk Assessment (HRA) or the Uniform Assessment System for New York (UAS-NY). They ask about the services you need. They also tell you about services you may want to think about getting. Your care team works with you to update your care plan at least every year or as needed if you have any changes in your health status.

SECTION 4 Important membership materials

Section 4.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. *[Insert for all plans except D-SNP AIPs: You should also show the provider your Medicaid card.]* You should also show the provider your Medicaid card. Sample membership card:

Chapter 1 Get started as a member

			
		UltraCare (HMO D-SNP) H0423-007	
Supercalifragilistic Expialidocious, Jr. MD			
Your Member ID #	Effective Date	Plan #	
XXXXXXXXXX	01/01/2023	(80840) 7790789912	
Payer ID #	RxBIN	RxPCN	RxGroup
13265	004336	MEDDADV	RX8541
Primary Care Physician (PCP)		PCP Phone #	
Your PCP Name		1 (212) 123-4567	

Send behavioral health and medical claims to:
MetroPlusHealth
PO Box 381508
Birmingham, AL 35283-1508

Email MetroPlusHealth: help.memberexperience@metroplus.org
 Visit the Website: metroplusmedicare.org

Customer Service 1 (866) 986-0356 TTY for the hearing impaired: 711	Rx Customer Services 1 (866) 693-4815	Mental Health Crisis (24/7) 1 (866) 728-1885 SMS capable for the hearing impaired	Dental Health Services 1 (844) 831-9099 TTY: 1 (800) 466-7566 DentaQuest
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DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your MetroPlus UltraCare (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 our plan membership card is damaged, lost, or stolen, call 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), right away and we'll send you a new card.

Section 4.2 Provider/Pharmacy Directory

The Provider/Pharmacy *Directory* found on metroplusmedicare.org 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.

The Provider/Pharmacy *Directory* found on metroplusmedicare.org lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is situations where it's unreasonable or not possible to get services in network), out-of-area dialysis services, and cases when MetroPlus UltraCare (HMO D-SNP) authorizes use of out-of-network providers.

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The most recent list of providers, network pharmacies and suppliers on our website at metroplusmedicare.org.

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

Section 4.3 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit in MetroPlus UltraCare (HMO D-SNP). The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List meets all Medicare requirements. Drugs included in the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed or replaced as described in Chapter 5, Section 6. Medicare approved the MetroPlus UltraCare (HMO D-SNP) Drug List.

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

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit metroplusmedicare.org or call 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.)

SECTION 5 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* *Your premium can be higher than this amount. Go to Section 4.1 for details.	Depending on your level of Extra Help: \$0 or up to \$40.50

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	Your Costs in 2027
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	\$9,850 If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Primary care office visits	\$0 per visit.
Specialist office visits	\$0 per visit.
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	\$0 copayment for unlimited inpatient days as medically necessary.

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Your Costs in 2027**Part D drug coverage**

(Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)

Part D drug coverage deductible

\$700 except for covered insulin products and most adult Part D vaccines

Depending on your level of Extra Help, you may pay \$0 during this phase.

Copayment during the Initial Coverage Stage:

Drug Tier 1: Generic drugs (including brand drugs treated as generic):

\$0 copay or
\$1.65 copay or
\$5.80 copay or
25% coinsurance (if no Extra Help)

All other drugs:
\$0 copay or
\$5.00 copay or
\$14.40 copay or
25% coinsurance (if no Extra Help)

You pay no more than \$35 per monthly supply of each covered insulin product on this tier.

Catastrophic Coverage Stage:
During this payment stage, you pay nothing for your covered Part D drugs.

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Your costs may include the following:

- Plan Premium (Section 5.1)
- Monthly Medicare Part B Premium (Section 5.2)
- Part D Late Enrollment Penalty (Section 5.3)
- Income Related Monthly Adjusted Amount (Section 5.4)
- Medicare Prescription Payment Plan Amount (Section 5.5)

Section 5.1 Plan premium

You do not pay a separate monthly plan premium for MetroPlus UltraCare (HMO D-SNP).

For 2026, the monthly plan premium is \$40.50. As a member of our plan, all of the \$40.50 plan premium is paid on your behalf by Extra Help.

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. *OR* The Extra Help program helps people with limited resources pay for their drugs. Learn more about these programs in Chapter 2, Section 7. If you qualify, enrolling in one of these programs might lower your monthly plan premium.

If you *already* get help from Extra Help NY Medicaid program, **the information about premiums in this Evidence of Coverage may not apply to you.** We have sent you a separate document, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this by **September 30, 2026**, call 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), 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, check your copy of the *Medicare & You 2027* handbook in the section called *2027 Medicare Cost*. Download a copy from the Medicare website ([medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you)) or order a printed copy by phone at 1-800-MEDICARE (800.633.4227). TTY users call 877.486.2048.

Chapter 1 Get started as a member

Section 5.2 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 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 UltraCare (HMO D-SNP) members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and Part B premium.

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

Section 5.3 Part D Late Enrollment Penalty

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

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

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

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Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable drug coverage, if the break in coverage was 63 days or more.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026 this average premium amount was \$34.50. This amount may change for 2027.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty would be 14% times \$34.50, which equals \$4.83. This rounds to \$4.80. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty.**

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

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

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you generally won't have another chance to ask for a reconsideration of that late enrollment penalty.

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

Chapter 1 Get started as a member

Section 5.4 Income Related Monthly Adjustment Amount

If you lose eligibility for this plan because of changes to your income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is 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/health-drug-plans/part-d/basics/costs](https://www.medicare.gov/health-drug-plans/part-d/basics/costs).

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

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 800.772.1213 (TTY users call 800.325.0778).

Section 5.5 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 6 More information about your monthly plan premium

Section 6.1 Your monthly plan premium won't change during the year

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

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

SECTION 7 Keep your plan membership record up to date

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

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

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

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

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

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 800.772.1213 (TTY users call 800.325.0778).

SECTION 8 How other insurance works with our plan

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

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

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
 - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2:

Phone numbers and resources

SECTION 1 MetroPlus UltraCare (HMO D-SNP) contacts

For help with claims, billing, or member card questions, call or write to MetroPlus UltraCare (HMO D-SNP) Member Services. We'll be happy to help you.

Member Services – Contact Information

Call	866.986.0356 Calls to this number are free. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.) Member Services also has free language interpreter services for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.)
Fax	212.908.5196
Write	MetroPlus Health Plan 50 Water Street, 7th fl. New York, NY 10004 Attn: Medicare Department
Website	metroplusmedicare.org

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

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

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

Call	866.986.0356 Calls to this number are free. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.)
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.)
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

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

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

Complaints about Medical Care – Contact Information

Call	866.986.0356 Calls to this number are free. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.)
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.)
Fax	212.908.5196
Write	MetroPlus Health Plan Complaints Manager 50 Water Street, 7th fl. New York, NY 10004
Medicare website	To submit a complaint about MetroPlus UltraCare (HMO D-SNP) directly to Medicare, go to medicare.gov/my/medicare-complaint .

How to ask us to pay our share of the cost for medical care or a drug you got

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

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

Payment Requests – Part C Medical Claims – Contact Information

Write	MetroPlus Health Plan Complaints Manager 50 Water Street, 7th fl.
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	New York, NY 10004
WEBSITE	metroplusmedicare.org

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 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 our dental vendor DentaQuest.

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

Requests – 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 Get help from Medicare

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

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The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information

Call	1-800-MEDICARE (800.633.4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	877.486.2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at medicare.gov/talk-to-someone .
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit medicare.gov to tell Medicare about any complaints you have about MetroPlus UltraCare (HMO D-SNP). To submit a complaint to Medicare, go to medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

Chapter 2 Phone numbers and resources

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In New York, the SHIP is called Health Insurance Information, Counseling and Assistance Program (HIICAP).

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

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

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	aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For New York, the Quality Improvement Organization is Commence Health.

Commence Health has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. (also Commence Health is an independent organization. It's not connected with our plan.

Contact Commence Health in any of these situations:

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

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- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

Commence Health (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 hearing or speaking.
Write	Commence Health BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
Website	commencehealthqio.cms.gov/en

SECTION 5 Social Security

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

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

Social Security– Contact Information

Call	800.772.1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	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.

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	Available 8 am to 7 pm, 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 UltraCare (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 help you get from Medicaid, contact the New York State Medicaid Program.

If you have questions about the help you get from Medicaid, contact New York State Medicaid Program. To get information from Medicaid, you can call the New York State 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).

New York State’s Medicaid Program – Contact Information

Call	800.541.2831 Monday through Friday, 8am to 8pm; Saturday, 9am to 1pm
TTY	711

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	This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
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
Website	health.ny.gov/health_care/medicaid

The New York State ombudsman program helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

Independent Consumer Advocacy Network (ICAN) – Contact Information

This ombudsman can help enrollees in our Health and Recovery Plan (HARP), and enrollees in our Medicaid Managed Care (MMC) plan that get long term services and supports.

Call	844.614.8800 Monday through Friday, 8am to 6pm
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
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

Community Health Access to Addiction and Mental Healthcare Project (CHAMP) – Contact Information

Call	888.614.5400 Monday through Wednesday, 9am to 7pm, Thursday through Friday, 9am to 4pm
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.

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Write	Community Health Access to Addiction and Mental Healthcare Project (CHAMP) Community Service Society of New York 633 Third Ave, 10th Floor New York, NY 10017 EMAIL: ombuds@oasas.ny.gov
Website	champny.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.

The New York State Long Term Care Ombudsman Program – Contact Information

Call	855.582.6769 Monday through Friday, 9am to 5pm
Write	2 Empire State Plaza, 5th Floor Albany, NY 12223 EMAIL: ombudsman@aging.ny.gov
Website	aging.ny.gov/long-term-care-ombudsman-program

SECTION 7 Programs to help people pay for prescription drugs

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

Extra Help from Medicare

If you have questions about Extra Help, call:

- 1-800-MEDICARE (800.633.4227). TTY users call 877.486.2048,
- The Social Security Office at 800.772.1213, between 8 am and 7 pm, Monday through Friday. TTY users call 800.325.0778; or
- Your State Medicaid Office at 800.541.2831 (Monday through Friday, 8am to 8pm; Saturday, 9am to 1pm). TTY users call 711.

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

- 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 get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at 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), 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 offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

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 800.332.3742 (TTY 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)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the AIDS Drug Assistance Program (ADAP) at 800.542.2437 or 844.682.4058. Hours of operation: Monday through Friday, 9am to 5pm.

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

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

EPIC (New York's State Pharmaceutical Assistance Program) – Contact Information

Call	800.332.3742 Monday through Friday, 8am to 5pm
TTY	800.290.9138 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	EPIC P.O. Box 15018 Albany, NY 12212-5018 Email: nysdohepic@primetherapeutics.com
Website	health.ny.gov/health_care/epic

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare UltraCare with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027; you do not need to submit a new election request to continue participating in 2027.** Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call Member Services at 866.986.0356 (TTY users should call 711), hours are Monday through Friday, 8am

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to 8pm, and Saturday, 9am to 5pm (After-hours answering service: 800.442.2560), or visit [medicare.gov](https://www.medicare.gov).

Medicare Prescription Payment Plan – Contact Information

Call	866.986.0356 Calls to this number are free. Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.) Member Services also has free language interpreter services for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.)
Fax	212.908.5196
Write	MetroPlus Health Plan 50 Water Street, 7th fl. New York, NY 10004 Attn: Medicare Department
Website	metroplusmedicare.org

SECTION 8 Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information

Call	877.772.5772 Calls to this number are free.
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	Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	312.751.4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren’t free.
Website	RRB.gov

SECTION 9 If 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, call the employer/union benefits administrator or 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), with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You can call 1-800-MEDICARE (800.633.4227) with questions about your Medicare coverage under this plan. TTY users call 877.486.2048.

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

CHAPTER 3:

Using our plan for your medical and other covered services

SECTION 1 How to get medical care and other services as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care and other services covered. For details on what medical care and other services our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing *or* 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 Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care and other services to be covered by our plan

As a Medicare health plan, MetroPlus UltraCare (HMO D-SNP) must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare (Please see Chapter 4).

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

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.

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- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
 - In most situations, our plan must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
 - You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (see Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means that you have to pay the provider in full for services you get. Here are 3 exceptions:
 - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
 - If you need medical care that Medicare 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. Prior authorization from our plan is required in advance of obtaining out-of-network services. In this situation, we'll cover these services if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
 - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care and other services

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 to choose a 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

Chapter 3 Using our plan for your medical and other covered services

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.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP.

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 Medical care and other services you can get without a PCP referral

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

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

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

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

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

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 service 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

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above, MetroPlus will have a special outside physician review the request and make the decision regarding the test.

When a specialist or another network provider leaves our plan

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
 - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. You must obtain prior authorization before obtaining service.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

Chapter 3 Using our plan for your medical and other covered services

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 get services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover dialysis services for ESRD members who have traveled outside your plan's service area and aren't able to access contracted ESRD providers.

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

Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network. However, our plan covers Emergency care both in the U.S. and worldwide (outside the U.S.) although Medicare does not provide coverage for emergency medical care outside the United States and its territories.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us

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about your emergency care, usually within 48 hours. Call Member Services at 866.986.0356. (TTY users 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.

Covered services in 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 giving you emergency care will decide when your condition is stable and when the medical emergency is over.

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

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

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

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

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

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

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

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 doesn't cover urgently needed services you get outside of the United States and its territories.

Section 3.3 Get care during a disaster

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

Visit metroplus.org for information on how to get needed care during a disaster.

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

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

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan

MetroPlus UltraCare (HMO D-SNP) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, or you get services out-of-network without authorization that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. 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 Medical services 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 ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

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

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain

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benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

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

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

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

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

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

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

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.

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

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at [medicare.gov/coverage/clinical-research-studies](https://www.medicare.gov/coverage/clinical-research-studies).) You can also call 1-800-MEDICARE (800.633.4227). TTY users call 877.486.2048.

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

Section 6.1 A religious non-medical health care institution

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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.

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- If you get services from this institution provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't 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 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

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

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count.

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage MetroPlus UltraCare (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 UltraCare (HMO D-SNP) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

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

CHAPTER 4:

Medical Benefits Chart

(what's covered)

SECTION 1 Understanding covered services

The Medical Benefits Chart lists your covered services as a member of MetroPlus UltraCare (HMO D-SNP). This section also gives information about medical services that aren't covered, and explains limits on certain services.

Section 1.1 You pay nothing for your covered services

Because you get help from Medicaid, you pay nothing for your covered services as long as you follow our plans' rules for getting your care. (Go to Chapter 3 for more information about our plans' rules for getting your care.)

Section 1.4 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Note: Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. You're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Medicare UltraCare plans have limits on the amount you have to pay out-of-pocket each year for medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2027 the MOOP amount is \$9,850.**

The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this maximum out-of-pocket amount. Because you get help from Medicaid, you pay nothing for your covered services as long as you follow our plans' rules for getting your care. (Go to Chapter 3 for more information about our plans' rules for getting your care.)

The amounts you pay for plan premiums and Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are addressed in the Medical Benefits

Chapter 4 Medical Benefits Chart (what's covered)

Chart. If you reach the maximum out-of-pocket amount of \$9,850, you won't 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 your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

The Medical Benefits Chart on the next pages lists the services MetroPlus UltraCare (HMO D-SNP) covers (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare and Medicaid covered services must be provided according to Medicare and Medicaid coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered unless it's emergency or urgent care, or unless our plan or a network provider gave you a referral. This means that you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk.
- 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.

Chapter 4 Medical Benefits Chart (what's covered)

Other important things to know about our coverage:

- You're covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services. Medicaid also covers services Medicare doesn't cover, like long-term care, over-the-counter drugs, home and community-based services, or other Medicaid-only services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at [medicare.gov](https://www.medicare.gov) or ask for a copy by calling 1-800-MEDICARE (800.633.4227). TTY users call 877.486.2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.
- MetroPlus UltraCare (HMO D-SNP) is a Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) that combines Medicare coverage with Medicaid benefits including long-term services and supports, designed for members who require nursing home level of care. Please see the Medical Benefits Chart for a description of benefits. For a description of additional Medicaid benefits and services available to MetroPlus UltraCare (HMO D-SNP) members, please see Chapter 4, Section 2.2. Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (See Chapter 3 for more information about the plans' rules for getting your care.)
- If you lose your New York State Medicaid Program eligibility but can be expected to regain it within 3 month(s) or 90 days, we'll continue to provide all Medicare UltraCare-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. During the grace period, you will be responsible for any copayments, coinsurance, premiums and/or deductible for which Medicaid would otherwise cover had you not lost your Medicaid eligibility. The amount you pay for Medicare-covered services may increase during this period. 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) for additional information.

You don't pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.

Chapter 4 Medical Benefits Chart (what's covered)

Important Benefit Information for Enrollees with Chronic Conditions

- If you're diagnosed with any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
 - Chronic alcohol use disorder and other substance use disorders (SUDs); Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes mellitus; Overweight, Obesity, Metabolic syndrome; Chronic gastrointestinal disease; Chronic kidney disease (CKD); Severe hematologic disorders; HIV/AIDS, Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke; Post-organ transplantation; Immunodeficiency and Immunosuppressive disorders; Conditions associated with cognitive impairment; Conditions with functional challenges; Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell; Conditions that require continued therapy services in order for individuals to maintain or retain functioning.
 - Eligible members will be identified by the MetroPlus 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.
- For more detail, go to the *Special Supplemental Benefits for the Chronically Ill* row in the Medical Benefits Chart below.
- Contact us to find out exactly which benefits you may be eligible for.



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

Medical Benefits Chart

Covered Service	What you pay
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain* Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • 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 • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the	There is no coinsurance, copayment, or deductible for Acupuncture for chronic low back pain. *Prior authorization is required.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
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. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations.	
Acupuncture (Supplemental)* Our plan also covers unlimited supplemental visits per year for other conditions, including chronic low back pain. Members must use a participating network provider.	There is no coinsurance, copayment, or deductible for Acupuncture (Supplemental) *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 if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	There is no coinsurance, copayment, or deductible for Ambulance services. *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 <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i>	There is no coinsurance, copayment, or deductible for the annual wellness visit.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
visit to be covered for annual wellness visits after you've had Part B for 12 months.	
 Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	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 aged 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. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program	There is no coinsurance, copayment, or deductible for Cardiac rehabilitation services. Referral is required. *Prior authorization is required for nonemergency services.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	
 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 screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
 Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	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 a vertebral subluxation	There is no coinsurance, copayment, or deductible for chiropractic services. Referral is required. *Prior authorization is required for non-emergency services.
 Colorectal cancer screening The following screening tests are covered:	There is no coinsurance, copayment, or deductible for a Medicare-covered

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
• 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 aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other	colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and subject to coinsurance. As a MetroPlus UltraCare (HMO D-SNP) members you pay \$0 for the diagnostic exam.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services* In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover Medicare-covered dental services including: • For otherwise non covered 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. If you are a MetroPlusHealth Dual Advantage or Medicaid Advantage Plus Member (for beneficiaries who qualify for both Medicare and Medicaid, also known as dual-eligible), we cover the New York State Medicaid Program Dental benefit as a Medicare Advantage supplemental benefit. For dual-eligible members, MetroPlusHealth follows the NYS Medicaid Program's coverage criteria for diagnostic, preventative, restorative, endodontics, periodontics, prosthodontics, implants, and orthodontics. Preventive Services:	There is no coinsurance, copayment, or deductible for covered preventive and comprehensive services. Services must be obtained through the DentaQuest dental network. *Prior authorization is required.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
Members are eligible for each of the following services every 6 months: • Oral Exams (frequency of oral exams varies based on the type of exam, based on what is deemed appropriate per ADA guidelines) • Prophylaxis (Cleaning) • Fluoride Varnish (once every 3 months) • Dental X-rays (frequency of dental X-rays varies based on the type of X-ray, based on what is deemed appropriate per ADA guidelines) Restorative services: • Tooth fillings (1 every 24 months per tooth) • Crowns – single restoration, once every 60 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 Endodontics services: Root canal therapy and retreatment of previous root canals, 1 per lifetime per tooth Periodontics services: • Periodontal maintenance procedures following active therapy – 1 every 6 months • Guided tissue regeneration and tissue grafts – (only covered for implants) • Osseous surgery – including elevation of a full thickness flap and closure at 1 every 60 months per quadrant • Gingivectomy or gingivoplasty – four or more contiguous teeth or teeth bounded spaces per quadrant – 1 every 12 months • Clinical crown lengthening – 1 per lifetime • Periodontal scaling and root planning – four or more teeth per quadrant – 1 every 24 months Removable Dentures: Complete and partial removable dentures (adjustments, repairs, rebase and relines).	

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
Fixed Prosthodontics Services: • Fixed dentures-pontics and associated crowns and retainers • Implants and Associated Services • Maxillofacial Prosthetics Oral and Maxillofacial surgery: Extractions Alveoloplasty 1 per quadrant per lifetime Vestibuloplasty 2 per arc per 36 months Oral Surgery Procedures Adjunctive services: • Office visit for observation – 4 visits per 12 months • Palliative Treatment (2 per 12 months) • Consultations (1 per 6 months) Accessing Dental Benefits MetroPlus UltraCare (HMO D-SNP) only allows for in-network dental coverage. To find a Dentist that participates in your plan, please use the “Find a Dentist” tool on the MetroPlusHealth website, metroplus.org/search-providers/, or contact Member Services at the number on the back of your MetroPlusHealth ID card. You can also request a list of participating dental providers. Urgently needed dental services are covered only when received through a participating dental provider. If you have a medical emergency, please visit an emergency department. 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.	

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
 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 We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	the Medicare-covered diabetes screening tests.
 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 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting. • Diabetes self-management training under certain conditions.	There is no coinsurance, copayment, or deductible for Diabetes self-management training, diabetic services, and supplies. 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*	There is no coinsurance, copayment, or deductible

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
(For a definition of durable medical equipment, go to Chapter 12 and Chapter 3) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. Generally, MetroPlus UltraCare (HMO D-SNP) covers any DME covered by Original Medicare from the brands and manufacturers on this list. We won't cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. If you're new to MetroPlus UltraCare (HMO D-SNP) and using a brand of DME not on our list, we'll continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.) If you (or your provider) don't agree with our plan's coverage decision, you or your provider can file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, go to Chapter 9.)	for Durable medical equipment (DME) and related supplies. *Prior authorization is required Your cost sharing for Medicare oxygen equipment coverage is \$0 copay. Your cost sharing won't change after you're enrolled for 36 months.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may	There is no coinsurance, copayment, or deductible for emergency care. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered OR you must have your inpatient care

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services 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.	at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital.
Fitness Benefit MetroPlus UltraCare (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 UltraCare (HMO D-SNP) will not provide reimbursement for equipment, clothing, vitamins, or other services that may be offered by the facility (massages, yoga, etc.).	There is no coinsurance, copayment, or deductible for Fitness Benefit.
Flex Card Members will receive a \$780 flex card benefit per quarter (no rollover to next quarter) that can be used to purchase Over the Counter (OTC) items, groceries, home utilities (water, gas, electricity, internet services), Personal Emergency Response	There is no coinsurance, copayment, or deductible for Flex Card. Important Note: Your Flex card allowance can only be used (except for

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
System (PERS), bathroom safety devices, pet supplies, chiropractor visits and rent assistance (Rent assistance: Exclusively via the Visa network).* Flex card benefit will be part of the Combined Supplemental Benefits package. Unused Flex card balance will expire at the end of each quarter. Any unused amount will not carry over to the subsequent calendar year. Please call Member Services to learn more about your Flex card benefit. *Note: For food, utilities, pet supplies, and rent assistance, additional conditions apply. For further details, please see the <i>Important Note</i> under “Special supplemental benefits for the chronically ill,” later in this section.	OTC) if you are eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI). Please see the Special Supplemental Benefit for the Chronically Ill (SSBCI) row for additional details.
 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.	There is no coinsurance, copayment, or deductible for Health and wellness education programs.
Hearing services* Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. Our plan also covers the following supplemental hearing services: • Hearing aid (all types) Per Year (maximum benefit of \$2,000 for both ears per year). • Hearing aid fitting: 1 routine hearing aid fitting per year • Hearing routine exam: 1 routine Exam per year	There is no coinsurance, copayment, or deductible for Medicare covered diagnostic hearing and balance exams. There is no coinsurance, copayment, or deductible for each Medicaid covered hearing service. There is no coinsurance, copayment, or deductible for hearing aid.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
	*Prior authorization is required for Medicaid-covered hearing services. *Prior authorization is required for hearing aid.
 HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: - One screening exam every 12 months If you are pregnant, we cover: - Up to 3 screening exams during a pregnancy	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care* Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't 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	There's no coinsurance, copayment, or deductible for members eligible for home health agency care. *Prior authorization is required.
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).	There's no coinsurance, copayment, or deductible for members eligible for home infusion therapy. *Prior authorization is required.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier 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.	

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services	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 UltraCare (HMO D-SNP). There's no coinsurance, copayment, or deductible for members eligible for a one-time hospice consultation.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare For services covered by MetroPlus UltraCare (HMO D-SNP) but not covered by Medicare Part A or B: MetroPlus UltraCare (HMO D-SNP) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. For drugs that may be covered by our plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4). Note: If you need non-hospice care (care that's not related to your terminal prognosis), 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've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B - COVID-19 vaccines - Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
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're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include but aren't 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 abuse services • 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'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're 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 UltraCare (HMO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion.	There is no coinsurance, copayment, or deductible for inpatient hospital care. There is no coinsurance, copayment, or deductible for unlimited inpatient days as medically necessary. *Prior authorization is required.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
- Blood – including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood you need. You must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered starting with the first pint. - 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're not sure if you're an inpatient or an outpatient, ask the hospital staff. - Get more information from the Medicare fact sheet <i>Medicare Hospital Benefits</i> available at medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (800.633.4227). TTY users call 877.486.2048.	
Inpatient Rehabilitation (In Hospital)*	There is no coinsurance, copayment, or deductible for inpatient Rehabilitation (In Hospital). *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.	There is no coinsurance, copayment, or deductible for inpatient services in a psychiatric hospital. There is no coinsurance, copayment, or deductible for unlimited inpatient days as medically necessary. *Prior authorization is required.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay* If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • 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	0 copay for each primary care provider (PCP) and specialist visit. \$0 copay for laboratory services. \$0 copay for X-rays. \$0 copay for diagnostic radiology, procedures and tests. \$0 copay for therapeutic radiology services. \$0 copay for medical and surgical supplies. \$0 copay for prosthetic devices. \$0 copay 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. *Prior authorization is required for physical, speech, and occupational therapy services for more than 10 visits in a year.

Covered Service	What you pay
 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 the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare UltraCare, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed in the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medically Managed Detox – Inpatient (In Hospital)*	There is no coinsurance, copayment, or deductible for members eligible for Medically Managed Detox Inpatient (In Hospital). *Prior authorization is required.
Medically Supervised Detox – Inpatient (In Hospital)*	There is no coinsurance, copayment, or deductible for members eligible for Medically Supervised Detox – Inpatient (In Hospital). *Prior authorization is required.
Medically Supervised Detox – Outpatient (In Hospital)*	There is no coinsurance, copayment, or deductible for members eligible for Medically Supervised Detox – Outpatient (In Hospital).

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
 Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people 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 sustain weight loss and a healthy lifestyle.	*Prior authorization is required. There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs* These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab) 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 • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug	\$0 copay. *Some Part B drugs may be subject to Prior Authorization or Step Therapy. Insulin covered under Part B (for example, short acting insulin or 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.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions. (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin	

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) This 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 Part B and most adult vaccines under our Part D drug benefit. We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.	
Nutritional/Dietary Benefit The plan covers unlimited (visits), 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 unlimited visits per year (Settings: Individual and Group).
 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 get coverage of services to treat OUD through an Opioid	You pay \$0 copayment.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
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 counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but aren't 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. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem • Other outpatient diagnostic tests.	Depending on your level of Medicaid eligibility: \$0 copay for X-rays. \$0 copay for diagnostic radiology, procedures and tests. \$0 copay for therapeutic radiology services. \$0 copay for medical and surgical supplies. \$0 copay for laboratory services. \$0 copay 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.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
	Referral required for the following: Diagnostic Procedures/Tests, Lab Services, Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Ray Services, Outpatient Blood 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 Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet <i>Medicare Hospital Benefits</i> available at medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (800.633.4227). TTY users call 877.486.2048.	You pay \$0 copayment.
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 aren't limited to:	You pay \$0 copayment.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
• 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 you can't give yourself Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), 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.	You pay \$0 copayment 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).	You pay \$0 copayment for each physical, occupational, and/or speech language therapy visit. *Prior authorization is required for more than 10 visits in a year.
Outpatient substance use disorder services Outpatient Substance Use Disorder treatment in the outpatient department of a hospital to patients who, for	\$0 copay for each individual or group therapy visit.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
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.	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	\$0 copay for each ambulatory surgery center visit. \$0 copay for each outpatient hospital visit.
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 \$780 flex card benefit per quarter (no rollover to next quarter) that can be used to purchase Over the Counter (OTC) items, groceries, home utilities (water, gas, electricity, internet services), Personal Emergency Response System (PERS), bathroom safety devices, pet supplies, chiropractor visits and rent assistance (Rent assistance: Exclusively via the Visa network).* Flex card benefit will be part of the Combined Supplemental Benefits package. Unused Flex card balance will expire at the end of each quarter. Any unused amount will not carry over to the subsequent calendar year. Please call Member Services to learn more about your Flex card benefit.	There is no coinsurance, copayment, or deductible for Flex Card. \$780 flex card per quarter (no rollover to next quarter) that can be used to purchase Over the Counter (OTC) items. Important Note: Your Flex card allowance can only be used for (except OTC) if you are eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI). Please see the Special Supplemental Benefit for the Chronically Ill (SSBCI) row for additional details.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
*Note: For food, utilities, pet supplies, and rent assistance, additional conditions apply. For further details, please see the <i>Important Note</i> under “Special supplemental benefits for the chronically ill,” later in this section.	
Partial hospitalization services and intensive outpatient services <i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. <i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	There is no coinsurance, copayment, or deductible for Partial hospitalization services and intensive outpatient services. Notice of Admission is required.
Personal Emergency Response System Personal Emergency Response System (PERS) is covered under the Flex card benefit. Members will receive a \$780 flex card benefit per quarter (no rollover to next quarter) that can be used to purchase Over the Counter (OTC) items, groceries, home utilities (water, gas, electricity, internet services), Personal Emergency Response System (PERS), bathroom safety devices, pet supplies, chiropractor visits and rent assistance (Rent assistance: Exclusively via the Visa network).* Flex card benefit will be part of the Combined Supplemental Benefits package. Unused Flex card balance will expire at the end of each quarter. Any unused amount will not carry over to the subsequent calendar year.	There is no coinsurance, copayment, or deductible for Personal Emergency Response System (PERS). \$780 flex card per quarter (no rollover to next quarter) that can be used to purchase Over the Counter (OTC) items. Important Note: Your Flex card allowance can only be used for (except OTC) if you are eligible for Special Supplemental

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
Please call Member Services to learn more about your Flex card benefit. <i>*Note: For food, utilities, pet supplies, and rent assistance, additional conditions apply. For further details, please see the Important Note under “Special supplemental benefits for the chronically ill,” later in this section.</i>	Benefits for the Chronically Ill (SSBCI). Please see the Special Supplemental Benefit for the Chronically Ill (SSBCI) row for additional details.
Physician/practitioner services, including doctor's office visits Covered services include: - Medically necessary medical care or surgery services you get 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. - 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. - 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	\$0 copay for each primary care provider (PCP) in-person office visit. \$0 copay for each specialist in-person office visit. \$0 copay for diagnostic hearing and balance exams. \$0 copay 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 copay for Medicare-covered non-routine dental care. Services must be obtained through the

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
our website at metroplusmedicare.org for information on how to access our telehealth provider. Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare. • 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 • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders • 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: ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: ○ You're not a new patient and ○ The evaluation isn't related to an office visit in the past 7 days and ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment	DentaQuest dental network.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
• Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery	
Podiatry services* Covered services include: • 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 12 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.	There is no coinsurance, copayment, or deductible for 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).	There is no coinsurance, copayment, or deductible for Post Discharge Meals. *Prior authorization is required.
 Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we	There is no coinsurance, copayment, or deductible for the PrEP benefit.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months • One time hepatitis B virus screening	
 Prostate cancer screening exams For men aged 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.
Prosthetic and orthotic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to <i>Vision Care</i> later in this table for more detail.	There is no coinsurance, copayment, or deductible for prosthetic devices. There is no coinsurance, copayment, or deductible for Medicare-covered eyewear after cataract removal or cataract surgery. *Prior authorization is required for prosthetic devices.
Psychiatric Inpatient Services (in Hospital)	\$0 copay. 190-day lifetime maximum. Notice of Admission is required.
Pulmonary rehabilitation services*	There is no coinsurance, copayment, or deductible

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	Pulmonary rehabilitation services. *Prior authorization is required. Referral is required.
 Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (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 people, an LDCT is covered every 12 months. Eligible members are people age 50–77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. <i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
 Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945–1965. If you were born between 1945–1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
 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 2 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 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 Kidney diseases and dialysis 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 6 sessions of kidney disease education services per lifetime	\$0 copay for kidney disease education services. \$0 copay for dialysis treatments. Referral required for dialysis service.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to Medicare Part B drugs in this table.	
Skilled nursing facility (SNF) care* (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) A 3-day prior hospital stay is required. Covered services include but aren't 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 our plan of care (this includes substances naturally present in the body, such as blood clotting factors) • Blood – including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood you need — you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else.	\$0 copay. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a 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. There's no limit to the number of benefit periods. *Prior authorization is required.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
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 get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	
 Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Special supplemental benefits for the chronically ill Enrollees with chronic condition(s) that meet certain criteria may be eligible for Special Supplemental Benefits for the	\$0 copay for eligible members.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
Chronically Ill (SSBCI), such as healthy foods and home utilities. To qualify for these benefits an enrollee must meet all the following criteria: 1) Have one of the eligible chronic conditions listed below; 2) Be at high risk of hospitalization and/or other adverse health outcomes; 3) And require intensive care coordination. Eligible chronic conditions include: Chronic alcohol use disorder and other substance use disorders (SUDs); Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes mellitus; Overweight, Obesity, Metabolic syndrome; Chronic gastrointestinal disease; Chronic kidney disease (CKD); Severe hematologic disorders; HIV/AIDS, Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke; Post-organ transplantation; Immunodeficiency and Immunosuppressive disorders; Conditions associated with cognitive impairment; Conditions with functional challenges; Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell; Conditions that require continued therapy services in order for individuals to maintain or retain functioning. A chronic condition alone does not guarantee eligibility for this benefit. All eligibility requirements must be met before the benefit is provided. Those members eligible for SSBCI, MetroPlus Advantage Plan (HMO D-SNP) will receive a \$780 flex card benefit per quarter (no rollover to next quarter) that can be used to purchase Over the Counter (OTC) items, groceries, home utilities (water, gas, electricity, internet services), Personal Emergency Response System (PERS), bathroom safety devices, pet supplies, chiropractor visits and rent assistance (Rent assistance: Exclusively via the Visa network).* Flex card benefit will be part of the Combined Supplemental Benefits package. Unused Flex card balance will expire at the end of each quarter. Any unused amount will not carry over to the subsequent calendar year.	Important Note: Your Flex card allowance can only be used for (except OTC) if you are eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI).

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
Please call Member Services to learn more about your Flex card benefit. *Important Note: All members receive a Flex Card; however, only members who qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI) may use their Flex Card funds for food, utilities, pet supplies, and rent assistance. All members, even those that do not qualify, can use their Flex Card for OTC items, home and bathroom safety devices, chiropractic visits, and Personal Emergency Response System (PERS) services. To use your Flex Card for food, utilities, pet supplies, and rent assistance: 1) You must have a chronic condition, which includes but is not limited to: cardiovascular disorders, diabetes mellitus, kidney disease, cancer, or disabling mental health conditions, among other conditions not listed; 2) the plan must determine that you are “chronically ill;” and 3) these extra benefits must reasonably improve your health or function. Please note that additional conditions, limitations, and requirements may apply. For more details, please call Member Services at 866.986.0356. (TTY users 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.	
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	\$0 copay. *Prior authorization is required. Referral is required for Additional SET for PAD Service.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
• 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 (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) 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.	
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 UltraCare (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 UltraCare (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 Unlimited trips per year. (In addition: Members are covered for unlimited rides under their Medicaid coverage.) Please call MetroPlus UltraCare (HMO D-SNP) Member Services at least two days in advance. Routine/Non-emergency Transportation will be provided through a plan approved vendor called Modivcare.
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like	\$0 copay.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. This coverage is available within the United States.	
 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 for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery MetroPlus UltraCare (HMO D-SNP) also covers additional vision care services not covered by Original Medicare. 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	\$0 copay for Medicare-covered eye exams, including diagnosis and treatment of diseases and conditions of the eye. \$0 copay for Medicaid covered vision care services. \$0 copay for eyewear for up to \$500 per year. *Prior authorization may be required for certain Medicaid-covered vision services. This benefit can be combined with your Medicaid benefits to provide coverage for additional eyewear, or to purchase eyewear beyond the Medicaid spending limit.

Chapter 4 Medical Benefits Chart (what's covered)

Covered Service	What you pay
 Welcome to Medicare preventive visit Our plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. Important: We cover the <i>Welcome to Medicare</i> preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your <i>Welcome to Medicare</i> preventive visit.	There is no coinsurance, copayment, or deductible for the <i>Welcome to Medicare</i> preventive visit.

SECTION 3 Additional covered benefits (additional Medicaid benefits), as member of MetroPlus UltraCare (HMO D-SNP)

MetroPlus UltraCare (HMO D-SNP) is a Medicaid Advantage Plus (MAP) Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) that coordinates care and services available to you through both the Medicare and Medicaid programs, including long-term care services.

The following chart lists the additional Medicaid benefits and services available for MetroPlus UltraCare (HMO D-SNP) members. Please use your MetroPlus UltraCare (HMO D-SNP) member identification card to obtain the additional Medicaid benefits described in this section. There are some benefits that are only covered by New York State Fee-For-Service Medicaid and not MetroPlus UltraCare (HMO D-SNP). These services are listed in the next section, Services we do not cover (Exclusions). You will have to use your New York State-issued Medicaid card when obtaining the services that are only covered by New York State Fee-For-Service Medicaid.

Chapter 4 Medical Benefits Chart (what's covered)

Additional Medicaid-Covered Benefits that are covered for you	What you must pay when you get these services
Adult Day Health Care*	
Adult day health care is care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. 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.	\$0 copay. *Prior authorization is required.
Consumer Directed Personal Assistance Services (CDPAS)*	
This program lets you, or the person acting for you, hire, train, supervise, arrange back-up coverage, keep payroll records, and fire the person giving you personal care services. You can ask to use the CDPAS program at any time. You can disenroll from the program at any time. MetroPlus Health Plan will review the level of personal care services, home health aide services, and/or skilled nursing services you need and write you a plan of care.	\$0 copay. *Prior authorization is required.
Home-Delivered and Congregate Meals*	
Meals provided at home or in congregate settings, e.g., senior centers to individuals unable to prepare meals or have them prepared.	\$0 copay. *Prior authorization is required. Prior authorization is not required for post discharge meals. (Please refer to Chapter 4, Section 2 for more information on post-discharge meals)

Chapter 4 Medical Benefits Chart (what's covered)

Additional Medicaid-Covered Benefits that are covered for you	What you must pay when you get these services
Medical Social Services*	
Medical social services include assessing the need for, arranging for, and providing aid for social problems related to the maintenance of an individual in the home.	\$0 copay. *Prior authorization is required.
Nutrition	
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 of nutritional status and food preferences, planning for provision of appropriate dietary intake within your 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.	\$0 copay.
Personal Care Services*	
Provision of some or hands-on assistance with Activities of Daily Living (ADLs) with activities such as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks (meal preparation and housekeeping). Such services must be essential to the maintenance of your health and safety in your own home. Personal care must be ordered by a physician and must be medically necessary.	\$0 copay. *Prior authorization is required.

Chapter 4 Medical Benefits Chart (what's covered)

Additional Medicaid-Covered Benefits that are covered for you	What you must pay when you get these services
Personal Emergency Response Services (PERS)* Electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional, or environmental emergency.	\$0 copay. *Prior authorization is required.
Private Duty Nursing* Private duty nursing provides home care aides, companion care, and homemaker services and may include nursing services in your home or temporary place of residence. Private duty nursing services are covered when determined by the attending physician to be medically necessary. Nursing services may be intermittent, part-time, or continuous and provided in accordance with the ordering physician, registered physician assistant, or certified nurse practitioner's written treatment plan. Private duty nursing services must be provided by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse.	\$0 copay. *Prior authorization is required.
Social Day Care* Structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance.	\$0 copay. *Prior authorization is required.

Chapter 4 Medical Benefits Chart (what's covered)

Additional Medicaid-Covered Benefits that are covered for you	What you must pay when you get these services
Social and Environmental Supports*	
Services and items that support your medical needs and are included in your plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care.	\$0 copay. *Prior authorization is required.
Assertive Community Treatment (ACT)*	
ACT is a mobile team approach to comprehensive and flexible treatment, support, case management, and rehabilitation services. Many services are provided by ACT staff in the community or where you live. ACT programs deliver integrated services to recipients and adjust services over time to meet the person's goals and changing needs.	\$0 copay. *Prior authorization is required.
ACT is for individuals that have been diagnosed with serious mental illness or emotional problems.	
Continuing Day Treatment (CDT)*	
Provides seriously mentally ill adults with treatment designed to enhance or maintain current levels of functioning and skills and supports necessary to remain in the community and be more independent. Includes: assessment and treatment planning; discharge planning; medication therapy; medication education; case management; health screening and referral; rehabilitative readiness development; psychiatric rehabilitative readiness determination and referral; and symptom management.	\$0 copay. *Prior authorization is required.
You can attend several days per week with visits lasting more than an hour.	

Chapter 4 Medical Benefits Chart (what's covered)

Additional Medicaid-Covered Benefits that are covered for you	What you must pay when you get these services
Comprehensive Psychiatric Emergency Program (CPEP)	
A hospital-based program which provides triage, observation, evaluation, treatment, and referral of psychiatric emergency services and crisis supports, and beds for extended observation (up to 72 hours) to individuals who need emergency mental health services.	\$0 copay.
Personalization Recovery Oriented Services (PROS)	
A complete recovery-oriented program if you have severe and ongoing mental illness. The goal of the program is to combine treatment, support, rehabilitation, and therapy to aid in your recovery.	\$0 copay.
Crisis Intervention (Mobile Crisis, Crisis Residence, and crisis stabilization)	
An in-community service that responds to individuals experiencing a mental health and/or addiction crisis.	\$0 copay.
Medically Supervised Detox – Inpatient	
Programs offer inpatient treatment for moderate withdrawal and nonacute physical or psychiatric complications and include supervision under the care of a physician. Some of the services you can receive are a medical assessment within twenty-four (24) hours of admission and medical supervision of intoxication and withdrawal conditions.	\$0 copay.
Addiction Treatment Center (ATC) – Inpatient Rehabilitation (Covered in OASAS-certified inpatient rehabilitation operated by hospital, freestanding/community-based facility)*	\$0 copay. *Prior authorization is required.
Provides individualized care and supports long-term recovery services.	

Chapter 4 Medical Benefits Chart (what's covered)

Additional Medicaid-Covered Benefits that are covered for you	What you must pay when you get these services
Residential Services – Part 820 (Covered in freestanding/ community based residential OASAS-certified, not covered in hospital) Provides 24/7 structured treatment/recovery (stabilization, rehabilitation, and integration) services in a residential setting provided by office certified programs to individuals recovering from substance use disorder.	\$0 copay.
Community Oriented Recovery and Empowerment (CORE) Services (Covered in the setting best suited to support goal acquisition, including in the individual's home and other community-based locations. PSR, FST, and Peer Support may be delivered onsite and/or offsite. CPST is delivered offsite unless there is a clinical rationale for delivering services onsite for a limited basis.) Adult person-centered, recovery-oriented program, and mobile behavioral health supports to help build skills and promote community participation and independence. CORE Services require a recommendation of a Licensed Practitioner of the Healing Arts (LPHA). CORE consists of (4) services: • Community Psychiatric Support and Treatment (CPST) • Psychosocial Rehabilitation (PSR) • Family Support and Training (FST) • Empowerment Services – Peer Support	\$0 copay. Notice of admission is required.
Crisis Stabilization Centers – Part 600 (Covered in outpatient, free-standing facility, hospital-based centers) Provides 24/7 observation, evaluation, care, and treatment services to individuals who require support and assistance with mental health or substance use crisis. Services provided with emphasis on peer and recovery services.	\$0 copay.

SECTION 3.1 Services that are not covered by MetroPlus UltraCare (HMO D-SNP) but are available through Medicaid

The following services are not covered by MetroPlus UltraCare (HMO D-SNP) but are available through Medicaid:

Assisted Living Program	\$0 copay.
Certain Mental Health Services, including • Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family-Based Treatment Programs • Health Home (HH) and Health Home Plus (HH+) Care Management services • Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs • OMH Day Treatment • OASAS Residential Rehabilitation for Youth • Certified Community Behavioral Health Clinics (CCBHC) • OMH Residential Treatment Facility (RTF) • Crisis Intervention Services for Youth ages 18–20 For MAP enrollees up to the age of 21: • Children and Family Treatment and Support Services (CFTSS) • Children’s Home and Community Based Services (HCBS)	\$0 copay.

Chapter 4 Medical Benefits Chart (what's covered)

Certain Intellectual Disability and Developmental Disabilities Services, including: • Long-term therapies • Day Treatment • Medicaid Service Coordination • Services received under the Home and Community Based Services Waiver	\$0 copay.
Other Medicaid Services • Methadone Treatment • Directly Observed Therapy for TB (Tuberculosis) • HIV COBRA Case Management • Conversion or Reparative Therapy	\$0 copay.
Family Planning Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP)	\$0 copay.
Comprehensive Medicaid Case Management	\$0 copay.
Hospice services provided to Medicare Advantage member	\$0 copay.
Medicaid Pharmacy Benefits as allowed by State Law (select drug categories excluded from the Medicare Part D benefit)	\$0 copay.
Out-of-network Family Planning services under the direct access provisions	\$0 copay.

SECTION 4 Services that aren't covered by our plan OR Medicare OR Medicaid

This section tells you what services are excluded.

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

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

Services not covered by Medicare	Covered only under specific conditions
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.
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	May be covered through your additional Medicaid covered benefits.
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (Go to Chapter 3, Section 5 for more information on clinical research studies.)

Chapter 4 Medical Benefits Chart (what's covered)

Services not covered by Medicare	Covered only under specific conditions
not be generally accepted by the medical community.	
Fees charged for care by your immediate relatives or members of your household	May be covered through your additional Medicaid covered benefits.
Full-time nursing care in your home	Not covered under any condition.
Home-delivered meals	Our Plan covers meal benefits under supplemental benefits. May be covered through your additional Medicaid covered benefits.
Homemaker services include basic household help, including light housekeeping or light meal preparation	May be covered through your additional Medicaid covered benefits.
Naturopath services (uses natural or alternative treatments)	Not covered under any condition.
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care. May be covered as medically necessary. Prior authorization is required.
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. May be covered through your additional Medicaid covered benefits. May be covered as medically necessary. Prior authorization is required. Not covered when the provider or supplier are out of network and do not participate with Medicare.
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.

Chapter 4 Medical Benefits Chart (what's covered)

Services not covered by Medicare	Covered only under specific conditions
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. Covered under Flex card benefit.
Routine dental care, such as cleanings, fillings, or dentures	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	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. Routine eye examinations and eyeglasses are covered Medicaid benefits.
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 plan coverage for Part D drugs

How can you get information about your drug costs if you're getting Extra Help with your Part D 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're 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 material by **September 30, 2026**, call 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), and ask for the *LIS Rider*.

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

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

In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. For additional information on drugs covered by Medicaid, contact the New York State Medicaid Program at 800.541.2831, Monday through Friday 8am to 8pm, Saturday, 9am to 1pm (TTY 711).

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Go to Section 2) or you can fill your prescription through your plan's mail-order service.
- Your drug must be on our plan's Drug List (Go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by

Chapter 5 Using plan coverage for Part D drugs

certain references. (Go to Section 3 for more information about a medically accepted indication.)

- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information)

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

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

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

Section 2.1 Network pharmacies**Find a network pharmacy in your area**

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website (metroplusmedicare.org), and/or call 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.)

You may go to any of our network pharmacies.

If your pharmacy leaves the network

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

Specialized pharmacies

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, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty

Chapter 5 Using plan coverage for Part D drugs

getting your Part D drugs in an LTC facility, call 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.)

- 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 restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Pharmacy Directory* metroplusmedicare.org or call 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.)

Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail order are drugs you take on a regular basis, for a chronic or long-term medical condition. These drugs are marked as **NM** in our Drug List.

Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get information about filling your prescriptions by mail contact our 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.)

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 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 MetroPlusHealth member ID number and prescription number(s). If you want second-day or next-day delivery of your medications, you may request this form from the Customer Care representative for an additional charge.

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

After the pharmacy gets a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important to respond each time you're contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

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 start to process your

Chapter 5 Using plan coverage for Part D drugs

next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy five (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, contact us by calling 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.)

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

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

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers two (2) ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.)

1. Your *Pharmacy Directory* found on 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 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), for more information
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.3 for more information.

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

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

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

Chapter 5 Using plan coverage for Part D drugs

- 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 particularly 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.

If you must use an out-of-network pharmacy, you'll 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. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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

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

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

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

The Drug List only shows drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. 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.

Chapter 5 Using plan coverage for Part D drugs

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

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

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

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

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

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

Drugs that aren't 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, call 800.541.2831.

Our plan doesn't cover all prescription drugs.

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

Chapter 5 Using plan coverage for Part D drugs

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

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

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (metroplusmedicare.org). The Drug List on the website is always the most current.
- Call 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), to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.

Use our plan's "Real-Time Benefit Tool" (caremark.com) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at 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.)

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

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

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

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

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at 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), to learn what you or your provider can do to

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get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

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

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Member Services at 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), or on our website metroplusmedicare.org.

Quantity limits

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

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

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

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.

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

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

You may be able to get a temporary supply

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

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

- **If you're a new member**, we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan.
- **If you were in our plan last year**, we'll cover a temporary supply of your drug during the first **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'll allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll 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 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.)

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

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at 866.986.0356 (TTY users should call 711), hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm (After-hours answering

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service: 800.442.2560), to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

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

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

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

SECTION 6 Our Drug List can change during the year

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

- **Add or remove drugs from the Drug List.**
- **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 our plan's Drug List.

Information on changes to drug coverage

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

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Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
 - We may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and [*Plans that don't use tiers can omit* “on the same or lower cost-sharing tier and.”] with the same or fewer restrictions.
 - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
 - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List**
 - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be with the same or fewer restrictions.
 - We'll make these changes only if we add a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
 - We'll tell you at least 30 days before we make the change or tell you about the change and cover a 30-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
 - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you're taking that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
 - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

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- We'll 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 take.

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

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

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

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

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

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

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

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you appeal and the drug asked for is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

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

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

In addition, by law, the following categories of drugs listed below aren't covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. For additional information on drugs covered by Medicaid, call 800.541.2831.

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

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. For additional information on drugs covered by Medicaid, call 800.541.2831.

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card along with your NYS Medicaid Common Benefit Identification Card (CBIC) (if applicable) at the network pharmacy you choose. The network pharmacy will automatically bill our plan and NYS Medicaid (if applicable) for our share and/or Medicaid's share of the costs of your drug. You'll need to pay the pharmacy *your* share of the cost when you pick up your prescription.

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

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to reimburse you for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

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

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

Section 9.2 As a resident in a long-term care (LTC) facility

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

Check your *Pharmacy Directory* found on metroplusmedicare.org to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at 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.) If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

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

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

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

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

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Special note about creditable coverage:

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

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

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

Section 9.4 If you're in Medicare-certified hospice

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

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

SECTION 10 Programs on drug safety and managing medications

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

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

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time

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- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

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

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

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

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

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

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

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Section 10.2 Medication Therapy Management (MTM) program to help members manage 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 our members get the most benefit from the drugs they take.

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

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program call 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.)

CHAPTER 6:

What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

We use “drug” in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B 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 explains these rules. When you use our plan’s “Real-Time Benefit Tool” to look up drug coverage ([caremark.com](https://www.caremark.com)), the cost you see shows an estimate of the out-of-pocket costs you’re expected to pay. You can also get information provided in the “Real-Time Benefit Tool” by calling Member Services at 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: 800.442.25600.)

How can you get information about your drug costs if you’re getting 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 get Extra Help, **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, call 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), and ask for the *LIS Rider*.

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

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

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

Chapter 6 What you pay for Part D drugs

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

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

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

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

- The amount you pay for drugs when you're in the following drug payment stages:
 - The Deductible Stage
 - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, State Pharmaceutical Assistance Programs (SPAPs), and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$2,400 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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

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

- Your monthly plan premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare

Chapter 6 What you pay for Part D drugs

- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

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

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches \$2,400, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for MetroPlus UltraCare (HMO D-SNP) members

There are **3 drug payment stages** for your drug coverage under MetroPlus UltraCare (HMO D-SNP). How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

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

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

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

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends,

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and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).

- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

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

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

Section 3.1 Help us keep our information about your drug payments up to date

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

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
 - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
 - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
 - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.

Chapter 6 What you pay for Part D drugs

- If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by 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 get the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or have questions, call Member Services at 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.) Be sure to keep these reports.

SECTION 4 The Deductible Stage

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

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

If you don't get Extra Help, the Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you're in this payment stage, **you must pay the full cost of your drugs** until you reach our plan's deductible amount, which is \$700 for 2027. 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 negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay \$700 for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

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

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your 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 isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Pharmacy Directory* metroplusmedicare.org.

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

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

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

Tier	Standard retail in-network cost sharing (up to a 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; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1	Depending on your Extra Help, you pay: Copayment/Coinsurance as applicable during the Initial Coverage Stage: Generic drugs (including brand drugs treated as generic): \$0 copay or \$1.65 copay or \$5.80 copay or 25% coinsurance (if no Extra Help) You pay no more than \$35 per monthly supply of each covered insulin product on this tier. All other drugs: \$0 copay or \$5.00 copay or \$14.40 copay or 25% coinsurance (if no Extra Help)	Depending on your Extra Help, you pay: Copayment/Coinsurance as applicable during the Initial Coverage Stage: Generic drugs (including brand drugs treated as generic): \$0 copay or \$1.65 copay or \$5.80 copay or 25% coinsurance (if no Extra Help) You pay no more than \$35 per monthly supply of each covered insulin product on this tier. All other drugs: \$0 copay or \$5.00 copay or \$14.40 copay or 25% coinsurance (if no Extra Help)	Depending on your Extra Help, you pay: Copayment/Coinsurance as applicable during the Initial Coverage Stage: Generic drugs (including brand drugs treated as generic): \$0 copay or \$1.65 copay or \$5.80 copay or 25% coinsurance (if no Extra Help) You pay no more than \$35 per monthly supply of each covered insulin product on this tier. All other drugs: \$0 copay or \$5.00 copay or \$14.40 copay or 25% coinsurance (if no Extra Help)	Depending on your Extra Help, you pay: Copayment/Coinsurance as applicable during the Initial Coverage Stage: Generic drugs (including brand drugs treated as generic): \$0 copay or \$1.65 copay or \$5.80 copay or 5% coinsurance (if no Extra Help) You pay no more than \$35 per monthly supply of each covered insulin product on this tier. All other drugs: \$0 copay or \$5.00 copay or \$14.40 copay or 25% coinsurance (if no Extra Help)

Chapter 6 What you pay for Part D drugs

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

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

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

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

- If you're responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 Your costs for a long-term up to a 90-day) supply of a covered Part D 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.

Chapter 6 What you pay for Part D drugs**Your costs for a *long-term* (up to a 90-day) supply of a covered Part D drug**

Tier	Standard retail cost sharing (in-network) (up to a 90-day supply)	Mail-order cost sharing (up to a 90-day supply)
Cost-Sharing Tier 1	Depending on your Extra Help, you pay: Copayment/ Coinsurance as applicable during the Initial Coverage Stage: Generic drugs (including brand drugs treated as generic): \$0 copay or \$1.65 copay or \$5.80 copay or 25% coinsurance (if no Extra Help) You pay no more than \$35 per monthly supply of each covered insulin product on this tier. All other drugs: \$0 copay or \$5.00 copay or \$14.40 copay or 25% coinsurance (if no Extra Help)	Depending on your Extra Help, you pay: Copayment/ Coinsurance as applicable during the Initial Coverage Stage: Generic drugs (including brand drugs treated as generic): \$0 copay or \$1.65 copay or \$5.80 copay or 25% coinsurance (if no Extra Help) You pay no more than \$35 per monthly supply of each covered insulin product on this tier. All other drugs: \$0 copay or \$5.00 copay or \$14.40 copay or 25% coinsurance (if no Extra Help)

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,400. You then move to the Catastrophic Coverage Stage.

The *Part D EOB* that you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the \$2,400 out-of-pocket limit in a year.

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

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the \$2,400 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you stay in this payment stage until the end of the calendar year.

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

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Go to our plan's Drug List or call 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), for coverage and cost-sharing details about specific vaccines.

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

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

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

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

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

2. Where you get the vaccine.

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

3. Who gives you the vaccine.

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

Chapter 6 What you pay for Part D drugs

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

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

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

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

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

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

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

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

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your copayment for the vaccine itself.

Chapter 6 What you pay for Part D drugs

- 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 in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid.

CHAPTER 7:

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

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

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

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

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

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

- 1. When you got emergency or urgently needed medical care from a provider who's not in our plan's network**
 - You can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill our plan.
 - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.

Chapter 7 Asking us to pay our share of a bill for covered medical services or drugs

- You may get a bill from the provider asking for payment that you think you don't owe. Send us this bill, along with documentation of any payments you made.
 - If the provider is owed anything, we'll pay the provider directly.
 - If you already paid more than your share of the cost for the service, we'll 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 shouldn't pay

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

3. If you're retroactively enrolled in our plan

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

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited

Chapter 7 Asking us to pay our share of a bill for covered medical services or drugs

circumstances. Go to Chapter 5, Section 2.5 to learn more about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

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

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

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

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

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for 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'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

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

You can ask 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've 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 got the service, item, or within **3 years of the date you received the drug**.

Chapter 7 Asking us to pay our share of a bill for covered medical services or drugs

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

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

To request **payment for medical costs**, Mail your request for payment together with any bills or paid 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'll consider your request for payment and say yes or no

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

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

Chapter 7 Asking us to pay our share of a bill for covered medical services or drugs

explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you we won't pay for all or part of the medical care or drug, you can make an appeal

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

CHAPTER 8:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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, braille, large print, or other alternate formats, etc.)

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

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to

Chapter 8 Your rights and responsibilities

file a grievance with our plan by calling 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.) You can also file a complaint with Medicare by calling 1-800-MEDICARE (800.633.4227) or directly with the Office for Civil Rights 800.368.1019 or TTY 800.537.7697.

Sección 1.1 Debemos proporcionar información de una manera que funcione para usted y que sea coherente con sus sensibilidades culturales (en idiomas distintos del inglés, braille, letra grande u otros formatos alternativos, etc.).

Nuestro plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se proporcionen de manera culturalmente competente y sean accesibles para todos los afiliados, incluidos aquellos con dominio limitado del inglés, habilidades de lectura limitadas, discapacidad auditiva o aquellos con diversos orígenes culturales y étnicos. Ejemplos de cómo nuestro plan puede cumplir estos requisitos de accesibilidad incluyen, entre otros, la provisión de servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teléfono de teletipo).

Nuestro plan tiene servicios de intérprete gratuitos disponibles para responder preguntas de miembros que no hablan inglés. También podemos proporcionarle materiales en idiomas distintos del inglés, incluyendo español y chino, en braille, en letra grande u otros formatos alternativos sin costo si lo necesita. Debemos brindarle información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener información de nuestra parte de una manera que funcione para usted, llame a Servicios para Miembros al 866.986.0356. (Los usuarios de TTY deben llamar al 711). El horario es de lunes a viernes, de 8 a.m. a 8 p.m., y sábados, de 9 a.m. a 5 p.m. (Servicio de contestador automático fuera del horario de atención: 800.442.2560).

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

Si los proveedores en la red de nuestro plan para una especialidad no están disponibles, es responsabilidad de nuestro plan localizar proveedores especializados fuera de la red que le proporcionen la atención necesaria. En este caso, solo pagará el costo compartido de la red. Si se encuentra en una situación en la que no hay especialistas en la red de nuestro plan que cubran un servicio que necesita, llame a nuestro plan para obtener información sobre dónde obtener este servicio con el costo compartido de la red.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, para ver a una especialista en salud de la mujer o para encontrar un especialista en la red, llame para presentar una queja con nuestro plan

Chapter 8 Your rights and responsibilities

llamando a Servicios para Miembros al 866.986.0356. (Los usuarios de TTY deben llamar al 711). El horario es de lunes a viernes, de 8 a.m. a 8 p.m., y sábados, de 9 a.m. a 5 p.m. (Servicio de contestador automático fuera del horario de atención: 800.442.2560). 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 TTY 800.537.7697.

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

You have the right to choose a primary care provider (PCP) OR provider in our 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 our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

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

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

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

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health 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've given legal power to make decisions for you first*.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.

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- We are required to release health information to government agencies that are checking on quality of care.
- Because you're a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

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

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

As a member of MetroPlus UltraCare (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, call 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.)

- **Information about our plan.** This includes, for example, information about our plan's financial condition.

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

Section 1.5 You have the right to know about your treatment options and participate in decisions about your care

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

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

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

Chapter 8 Your rights and responsibilities

You have the right to give instructions about what's to be done if you can't 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're in this situation. This means *if you want to*, you can:

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

Legal documents you can use to give directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call 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), to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

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If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital did not follow the instructions in it, you can file a complaint with New York State Department of Health. Contact the Department of Health by:

- **Phone:** 866.712.7197
- **Mail:**
New York State Department of Health
Bureau of Consumer Services
99 Washington Ave/ One Commerce Plaza
16th Fl
Albany, NY 12210
- **E-mail:** mltccomplaints@health.ny.gov

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

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

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 800.368.1019 (TTY users call 800.537.7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected *and it's not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call our plan's Member Services at 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.)**
- **Call your local SHIP.** For contact information details, go to Chapter 2, Section 3.
- **Call Medicare** at 1-800-MEDICARE (800.633.4227) (TTY users call 877.486.2048).

Chapter 8 Your rights and responsibilities

- **Call Medicaid and state ombudsman programs:** For contact information details, go to Chapter 2, Section 6.

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call 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.)**
- **Call your local SHIP at 800.701.0501.** For contact information details, go to Chapter 2, Section 3.
- **Contact Medicare**
 - Visit [medicare.gov](https://www.medicare.gov) to read the publication *Medicare Rights & Protections* (available at: [Medicare Rights & Protections](#))
 - Call 1-800-MEDICARE (800.633.4227) (TTY users call 877.486.2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call 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.)

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.
 - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card and your Medicaid card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.

Chapter 8 Your rights and responsibilities

- Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
 - You must continue to pay your Medicare premiums to stay a member of our plan.
 - For most of your medical drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9:

If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you're having:

For some problems, you need to use the **process for coverage decisions and appeals**.

For other problems, you need to use the **process for making complaints** (also called grievances).

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

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

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 866.986.0356 (TTY users should call 711) for help. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.) In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

Medicare

You can also contact Medicare for help:

Call 1-800-MEDICARE (800.633.4227), 24 hours a day, 7 days a week. TTY users call 877.486.2048.

Visit [medicare.gov](https://www.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 Program. To get information directly from Medicaid, you can call the New York State Medicaid Program at 800.541.2831 Monday through Friday 8am to 8pm, Saturday 9am to 1pm (TTY 711). You can also visit the New York State Medicaid Program website: health.ny.gov/health_care/medicaid. You will also find Medicaid phone numbers and website URLs in Chapter 2, Section 6 of this document.

SECTION 3 Understanding Medicare and Medicaid complaints and appeals

You have Medicare and get help from Medicaid. Information in this chapter applies to **all** your Medicare and Medicaid benefits. This is called an integrated process because it combines, or integrates, Medicare and Medicaid processes.

Sometimes the Medicare and Medicaid processes aren't combined. In those situations, use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in **Section 6.4**.

SECTION 4 Which process to use for your problem

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

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to **Section 5, A guide to coverage decisions and appeals.**

No.

Go to **Section 11, How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

Coverage decisions and appeals

SECTION 5 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuse to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage

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decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

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

You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.

Go to **Section 6.4** of this chapter for more information about Level 2 appeals for medical care.

Part D appeals are discussed in Section 7 of this chapter.

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

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Section 5.1 Get help asking for a coverage decision or making an appeal

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

- **Call Member Services at 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.)
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 866.986.0356 (TTY users should call 711) and ask for the *Appointment of Representative* form. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.) (The form is also available at [CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf).)
 - For medical care, your doctor or other health care provider can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it'll be automatically forwarded to Level 2.
 - If your doctor or other health provider asks that a service or item that you're already getting be continued during your appeal, you may need to name your doctor or other prescriber as your representative to act on your behalf.
 - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.

If you want a friend, relative, or other person to be your representative, call Member Services at 866.986.0356 (TTY users should call 711) and ask for the *Appointment of Representative* form. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.) (The form is also available at [CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf).) This form gives that person permission to act on your behalf. It must be signed by you and the person you want to act on your behalf. You must give us a copy of the signed form.

We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send

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you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines, we give the details for each of these situations:

- **Section 6:** “Medical care: How to ask for a coverage decision or make an appeal”
- **Section 7:** “Part D drugs: How to ask for a coverage decision or make an appeal”
- **Section 8:** “How to ask us to cover a longer inpatient hospital stay if you think you’re being discharged too soon”
- **Section 9:** “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which information applies to you, call Member Services at 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.) You can also get help or information from your SHIP.

SECTION 6 Medical care: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting coverage for medical care or want us to pay you back for your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we’ll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you’re in any of the 5 following situations:

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1. You aren't getting certain medical care you want, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan won't approve the medical care your doctor or other health care provider wants to give you, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You got medical care that you believe our plan should cover, but we said we won't pay for this care. **Make an appeal. Section 6.3.**
4. You got and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You're told that coverage for certain medical care you've been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 8 and 9. Special rules apply to these types of care.

Section 6.2 How to ask for a coverage decision**Legal Terms:**

A coverage decision that involves your medical care is called an **organization determination**.

A **fast coverage decision** is called an **expedited determination**.

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

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, 24 hours for Part B drugs.

- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast**

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coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

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

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

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

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a **Part B drug**, we'll give you an answer **within 72 hours** after we get your request.

However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

If you believe we *shouldn't* take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 11 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

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However, if you ask for more time, or if we need more that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

If you believe we should *not* take extra days, you can file a fast complaint. (Go to Section 11 for information on complaints.) We'll call you as soon as we make the decision.

If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

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

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

Section 6.3 How to make a Level 1 appeal**Legal Terms:**

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

A fast appeal is also called an **expedited reconsideration**.

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

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

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2.

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

- **If you're asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.

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- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we'll send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We'll continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You'll also keep getting all other services or items (that aren't the subject of your appeal) with no changes.

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

- When we are reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
 - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will

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notify you in writing when it gets your appeal. Section 6.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
 - If you believe we *shouldn't* take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, go to **Section 11**.)
 - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**
- If we say no to part or all of what you asked for, we'll send you a letter.
 - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
 - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

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Section 6.4 The Level 2 appeal process**Legal Term:**

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

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

- If your problem is about a service or item that's usually **covered by Medicare**, we'll automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that's usually **covered by Medicaid**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you'll automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 169 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that's usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that's usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after getting our plan's decision letter.

If your problem is about a service or item Medicare usually covers:

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a free copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

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- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

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

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

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

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

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

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

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.

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- **If the independent review organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
 - Explains the decision.
 - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Tells you how to file a Level 3 appeal.
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.
 - The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item Medicaid usually covers:**Step 1: Ask for a Fair Hearing with the state.**

Level 2 of the appeals process for services usually covered by Medicaid is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 60 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

You can ask for a Fair Hearing with the state:

- **By phone:** 800.342.3334 (TTY call 711 and ask operator to call 877.502.6155)
- **By fax:** 518.473.6735
- **By internet:** otda.ny.gov/oah/FHReq.asp
- **By mail:** NYS Office of Temporary and Disability Assistance

Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

- **In person:**

For non-New York City residents:

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Office of Temporary and Disability Assistance
Office of Administrative Hearings
40 North Pearl Street
Albany, New York 12243

For New York City residents:
Office of Temporary and Disability Assistance
Office of Administrative Hearings
5 Beaver Street
New York, New York 10004

After you ask for a Fair Hearing, the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and the plan and decide whether our decision was wrong. If the State denies your request for a fast track Fair Hearing, they will call you and send you a letter. If your request for a fast track Fair Hearing is denied, the State will process your Fair Hearing in 90 days.

If the State approves your request for a fast track Fair Hearing, they will call you to give you the time and date of your hearing. All Fast Track Fair Hearings will be held by phone.

To prepare for the hearing:

- **We will send you a copy of the "evidence packet" before the hearing.** This is information we used to make our decision about your services. We will give this information to the hearing officer to explain our decision. 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 the evidence packet by the week before your hearing, you can call (1-800-MCO-PLAN) to ask for it.
- **You have the right to see your case file and other documents.** Your case file has your health records and may have more information about why your health care service was changed or not approved. You can also ask to see guidelines and any other document we used to make this decision. You can call (1-800-MCO-PLAN) to see your case file and other documents, or to ask for a free copy. Copies will only be mailed to you if you say you want them to be mailed.
- **You have a right to bring a person with you to help you at the hearing,** like a lawyer, a friend, a relative or someone else. At the hearing, you or this person can give the hearing officer something in writing, or just say why the decision was wrong. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.
- **You have the right to submit documents to support your case.** Bring a copy of any papers you think will help your case, such as doctor's letters, health care bills, and

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receipts. It may be helpful to bring a copy of this notice and all the pages that came with it to your hearing.

- **You may be able to get legal help** by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers" or go to lawhelpNY.org. In New York City, call 311.

External Appeal

You have other appeal rights if we said the service you asked for was:

1. not medically necessary;
2. experimental or investigational;
3. not different from care you can get in the plan's network; or
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 MetroPlus UltraCare (HMO D-SNP) 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.

You have **4 (four) months** from the date that we sent the decision letter on your Level 1 appeal to ask for an External Appeal. If you and MetroPlus UltraCare (HMO D-SNP) 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** (TTY users call 711) if you need help filing an External Appeal. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.) 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 External Appeal application:

- Call the Department of Financial Services at 800.400.8882
- Go to the Department of Financial Services' web site at dfs.ny.gov.
- Contact us at **866.986.0356** (TTY users call 711). Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.)

Your External Appeal will be decided in 30 days. More time (up to five work days) may be needed if the External Appeal reviewer asks for more information. You and MetroPlus UltraCare (HMO D-SNP) will be told the final decision within two days after the decision is made.

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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 Level 1 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 Level 1 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.

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.

Step 2: The Fair Hearing office gives you its answer.

The Fair Hearing office will tell you its decision in writing and explain the reasons.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service,** we must authorize or provide the service or item within 72 hours after we get the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal,** they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.)

If the decision is no for all or part of what you asked for, you can make another appeal.

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

Go to **Section 10** for more information on your appeal rights after Level 2.

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Section 6.5 If you're asking us to pay you back for a bill you got for medical care

We can't reimburse you directly for a Medicaid service or item. If you get a bill for Medicaid-covered services and items, send the bill to us. **Don't pay the bill yourself.** We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting the service or item.

Asking to be paid back for something you have already paid for

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. We can't reimburse you directly for a **Medicaid** service or item. If you get a bill for Medicaid covered services and items, send the bill to us. **Don't pay the bill yourself.** We'll contact the health care provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or items.

If you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a Medicaid service or item you paid for, ask us to make this coverage decision. We'll check to see if the medical care you paid for is a covered service. We'll also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the Medicare medical care is covered, we'll send you the payment for the cost within 60 calendar days after we get your request.
- If the Medicaid care that you paid a health care provider for is covered and you think we should pay the health care provider instead, we'll send your health care provider the payment for the cost within 60 calendar days after we get your request.

Then you'll need to contact your health care provider to get them to pay you back. If you haven't paid for the medical care, we'll send the payment directly to the health care provider.

- **If we say no to your request:** If the medical care isn't covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we'll not pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal.** If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 6.3. For appeals concerning reimbursement, note:

- We must give you our answer within 30 calendar days after we get your appeal.

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- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the health care provider within 60 calendar days.

SECTION 7 Part D drugs: How to ask for a coverage decision or make an appeal

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals**Legal Term:**

An initial coverage decision about your Part D drugs is called a **coverage determination**.

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that isn't on our plan's Drug List. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 7.2.**

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- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Section 7.2 Asking for an exception**Legal Terms:**

Asking for coverage of a drug that's not on the Drug List is a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is a **formulary exception**.

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception**.

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here is an example of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to all our drugs. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug when we agree to cover a drug not on the Drug list.

Section 7.3 Important things to know about asking for exceptions**Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as

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effective as the drug you're asking for and wouldn't cause more side effects or other health problems, we generally won't 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 our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 7.4 How to ask for a coverage decision, including an exception**Legal term:**

A fast coverage decision is called an **expedited coverage determination**.

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

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet 2 requirements:

- You must be asking for a *drug you didn't get yet*. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
 - Explains that we'll use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.

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- Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request* form or on our plan's form, which is available on our website metroplusmedicare.org. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement**, which is the medical reason for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.***Deadlines for a fast coverage decision***

- We must generally give you our answer **within 24 hours** after we get your request.
 - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must give you our answer **within 72 hours** after we get your request.

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- For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
- If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request.
 - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for**, we are also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

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

Section 7.5 How to make a Level 1 appeal**Legal Terms:**

An appeal to our plan about a Part D drug coverage decision is called a **plan redetermination**.

A fast appeal is called an **expedited redetermination**.

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

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request or** call us. Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us 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. Include your name, contact information, and information about your claim to help us process 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 asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request.
- We may contact you or your doctor or other prescriber to get more information.

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Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
 - If we don't give you a decision within 7 calendar days, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
 - If we don't meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for**, we are also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 7.6 How to make a Level 2 appeal**Legal Term**

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you'll include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
- You must make your appeal request **within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE. We'll let you know in writing if your request has been sent to the independent review organization.
- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

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Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the independent review organization agrees to give you a fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you have already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.***For fast appeals:***

- **If the independent review organization says yes to part or all of what you asked for**, we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If the independent organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug

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coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.

- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

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

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 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.) Or 1-800-MEDICARE (800.633.4227) (TTY users call 877.486.2048).

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1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **ask for an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we'll cover your hospital care for a longer time.

2. You'll be asked to sign the written notice to show that you got it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. Keep your copy of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Member Services at 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.) Or 1-800-MEDICARE (800.633.4227). TTY users call 877.486.2048. You can also get the notice online at [CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).

Section 8.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 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.) Or call

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your State Health Insurance Assistance Program (SHIP), for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.

Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 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.) Or 1-800-MEDICARE (800.633.4227). (TTY users call 877.486.2048.) Or you can get a sample notice online at [CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).

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Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.***What happens if the answer is yes?***

- If the independent review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says no, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says no to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to **Level 2** of the appeals process.

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Section 8.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.***If the independent review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further by going to Level 3.

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

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying for your care*.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 9.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal**. Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

- 1. You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we'll stop covering the care for you.
 - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
- 2. You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it *doesn't* mean you agree** with our plan's decision to stop care.

Section 9.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**

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- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call 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.) Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.

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- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers told us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then **we must keep providing your covered service for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say no, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say no to your Level 1 appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 appeal.

Section 9.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.***What happens if the independent review organization says yes?***

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further.

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

SECTION 10 Taking your appeal to Levels 3, 4 and 5

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may or may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
 - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

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If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An Administrative Law Judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.

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- If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	Are you unhappy with the quality of the care you got (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're being encouraged to leave our 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 our plan? - 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 about the <i>timeliness</i> of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint.

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Complaint	Example
	• You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint**Legal Terms:**

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Member Services at 866.986.0356 (TTY users should call 711) is usually the first step.** Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.) If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.

MetroPlus Health Plan 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 Floor
 New York, NY 10004
 Phone: 866.986.0356
 Fax: 212.908.3011

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

We will try to resolve your complaint over the phone or within 24 hours of receipt of complaint

- **Whether you call or write, you should call Member Services at 866.986.0356** (TTY users should call 711) **right away**. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.) You can make the complaint at any time after you had the problem you want to complain about

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 11.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 11.4 You can also tell Medicare and Medicaid about your complaint

You can submit a complaint about MetroPlus UltraCare (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to [medicare.gov/my/medicare-complaint](https://www.medicare.gov/my/medicare-complaint). You can also call 1-800-MEDICARE (800.633.4227). TTY/TDD users call 877.486.2048.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

You also have a right to contact the New York State Department of Health about your complaint. Contact the Department of Health by:

- **Phone:** 866.712.7197
- **Mail:**
New York State Department of Health
Bureau of Consumer Services
99 Washington Ave/ One Commerce Plaza
16th Fl
Albany, NY 12210
- **E-mail:** mltccomplaints@health.ny.gov

CHAPTER 10:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in MetroPlus UltraCare (HMO D-SNP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. If you receive Extra Help, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

- Call your State Medicaid Office at 800.541.2831 Monday through Friday 8am to 8pm, Saturday 9am to 1pm to learn about your Medicaid plan options.
- Other Medicare health plan options are available during the **Open Enrollment Period**. Section 2.2 tells you more about the Open Enrollment Period.

Chapter 10 Ending membership in our plan

- **Your membership will usually end on the first day of the month after we get your request to change your plan.** Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Open Enrollment Period

You can end your membership during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of coverage:
 - Another Medicare health plan, with or without drug coverage.
 - Original Medicare *with* a separate Medicare drug plan
 - Original Medicare *without* a separate Medicare drug plan.
 - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

You get Extra Help from Medicare to pay for your prescription drugs: If you switch to Original Medicare and don't enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you've opted out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.

Chapter 10 Ending membership in our plan

- **During the Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare UltraCare with or without drug coverage.
 - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare UltraCare, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit [medicare.gov](https://www.medicare.gov).

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for your Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)
- **Note:** If you're in a drug management program, you may only be eligible for certain Special Enrollment Periods. Chapter 5, Section 10 tells you more about drug management programs.
- **Note:** Section 2.1 tells you more about the special enrollment period for people with Medicaid.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (800.633.4227). TTY users call 877.486.2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

Chapter 10 Ending membership in our plan

- Another Medicare health plan with or without drug coverage,
- Original Medicare *with* a separate Medicare drug plan,
- Original Medicare *without* a separate Medicare drug plan.
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you get Extra Help from Medicare to pay for your drug coverage drugs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Your membership will usually end on the first day of the month after your request to change your plan.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at 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.)**
- Find the information in the ***Medicare & You 2027*** handbook
- Call **Medicare** at 1-800-MEDICARE (800.633.4227) (TTY users call 877.486.2048)

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from MetroPlus UltraCare (HMO D-SNP) when your new plan's coverage starts.
Original Medicare <i>with</i> a separate Medicare drug plan	• Enroll in the new Medicare drug plan.

Chapter 10 Ending membership in our plan

	You'll automatically be disenrolled from MetroPlus UltraCare (HMO D-SNP) when your new drug plan's coverage starts.
Original Medicare <i>without</i> a separate Medicare drug plan	Send us a written request to disenroll. Call Member Services at 866.986.0356 (TTY users should call 711) if you need more information on how to do this. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.) - You can also call Medicare at 1-800-MEDICARE (800.633.4227) and ask to be disenrolled. TTY users call 877.486.2048. - You'll be disenrolled from MetroPlus UltraCare (HMO D-SNP) when your coverage in Original Medicare starts.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your New York State Medicaid Program benefits, call at 800.541.2831 (TTY call 711) Monday through Friday 8am to 8pm, Saturday 9am to 1pm). Visit the website health.ny.gov/health_care/medicaid/. Ask how joining another plan or returning to Original Medicare affects how you get your New York State Medicaid Program coverage.

SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership ends, and your new Medicare and Medicaid coverage starts, you must continue to get your medical items, services and prescription drugs through our plan.

- Continue to use our network providers to get medical care.**
- Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 MetroPlus UltraCare (HMO D-SNP) must end your plan membership in certain situations

MetroPlus UltraCare (HMO D-SNP) must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you're no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. **Note:** When our Plan is notified that you have lost your Medicaid coverage, we will send you a notice. You will have 90 days from the date of that notice to regain your coverage. If you regain Medicaid within the 90-day period, you will remain enrolled in the MetroPlus UltraCare (HMO D-SNP). If you do not regain Medicaid within 90 days, you will be disenrolled from your MetroPlus UltraCare (HMO D-SNP), as Medicaid coverage is required to stay enrolled.
- If you don't pay your medical spenddown, if applicable.
- If you move out of our service area.
- If you're away from our service area for more than 6 months.
 - If you move or take a long trip, call 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), to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or national, or an eligible noncitizen.
- If you lie or withhold information about other insurance, you have that provides drug coverage.
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Chapter 10 Ending membership in our plan

- We must notify you in writing that you have 90 days to pay your plan premium before we end your membership.

If you have questions or want more information on when we can end your membership, call Member Services at 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.)

Section 5.1 We can't ask you to leave our plan for any health-related reason

MetroPlus UltraCare (HMO D-SNP) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (800.633.4227). TTY users call 877.486.2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare UltraCares, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 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](https://www.hhs.gov/ocr/index.html).

If you have a disability and need help with access to care, call 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.) If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, MetroPlus UltraCare (HMO D-SNP), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in

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subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.



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 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.
-

Chapter 11 Legal notices

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:** 800.303.9626, 7 days per week 8am to 8pm
 - **Medicare Members:** 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.
-

continued on next page

Chapter 11 Legal notices**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 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 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 877.696.6775, or visiting hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

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Chapter 11 Legal notices

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.

continued on next page

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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Chapter 11 Legal notices**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:

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 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 healthix.org or by calling 877.695.4749.	

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Chapter 11 Legal notices

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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Chapter 11 Legal notices

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:

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:** 800.303.9626, 7 days per week 8am to 8:00pm
- **Medicare Members:** 866.986.0356, 7 days per week, 8:00am to 8pm
- **TTY:** 711
- **E-mail:** PrivacyOfficer@metroplus.org

Chapter 11 Legal notices**Notice of Availability**

LANGUAGE SERVICES AND AUXILIARY AIDS AND SERVICES

ATTENTION: Language assistance services, and auxiliary aids and services, free of charge, are available to you. Call 1-866-986-0356 (TTY: 711).	English
ATENCIÓN: Tiene a su disposición, sin costo alguno, servicios de asistencia lingüística, y ayudas y servicios auxiliares. Llame al 1-866-986-0356 (TTY: 711).	Spanish
注意：您可以獲得免費的語言援助服務以及輔助工具和服務。請致電：1-866-986-0356（聽力障礙電傳：711）。	Chinese Cantonese
تتوفر خدمات المساعدة اللغوية، والوسائل المساعدة والخدمات الإضافية لك بشكلٍ تنبيه مجاني. اتصل على الرقم 1-866-986-0356 (الهاتف النصي: 711)	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스와 보조 지원 및 서비스를 무료로 이용하실 수 있습니다. 1-866-986-0356 (TTY: 711) 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ! Вы можете воспользоваться бесплатными услугами языковой помощи и вспомогательными устройствами/средствами для восприятия информации. Звоните по тел.: 1(866)986-0356 (телетайп: 711).	Russian
ATTENZIONE: sono disponibili gratuitamente per Lei servizi di assistenza linguistica, accanto ad altri ausili e servizi. Telefoni al numero 1-866-986-0356 (Per gli utenti TTY: telefoni al numero 711).	Italian
ATTENTION: Des services d'assistance linguistique ainsi que des aides et services auxiliaires sont mis gratuitement à votre disposition. Appelez le 1-866-986-0356 (TTY: 711).	French

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ATANSYON: Sèvis asistans lang yo ak sèvis ak èd konplemantè yo gratis e disponib pou ou. Rele nan 1-866-986-0356 (TTY: 711).	French Creole
לרשותכם שירותי סיוע בשפה, ועזרים ושירותים נלווים ללא אכטונג 1-866-986-0356 רופט תשלום. (TTY: 711).	Yiddish
UWAGA: Mogą Państwo bezpłatnie korzystać z pomocy językowej, pomocy dodatkowych oraz innych usług. Proszę dzwonić pod numer 1-866-986-0356 (TTY: 711).	Polish
PAUNAWA: Ang mga serbisyo ng tulong sa wika, at mga pantulong na tulong at serbisyo, na walang bayad, ay available sa iyo. Tumawag sa 1-866-986-0356 (TTY: 711).	Tagalog
মনোযোগ দিন: এখানে আপনার জন্য ভাষা সহায়তা পরিষেবা এবং অতিরিক্ত সাহায্য ও পরিষেবা বিনামূল্যে উপলভ্য রয়েছে। 1-866-986-0356 (TTY: 711)-তে কল করুন।	Bengali
VINI RE: Shërbime për ndihmë gjuhësore, si dhe ndihmë dhe shërbimet ndihmëse, janë në dispozicion për ju pa pagesë. Telefononi 1-866-986-0356 (TTY: 711).	Albanian
ΠΡΟΣΟΧΗ: Οι υπηρεσίες βοήθειας στη γλώσσα σας και τα βοηθήματα και οι υποστηρικτικές υπηρεσίες, διατίθενται δωρεάν σε εσάς. Καλέστε τον αριθμό 1-866-986-0356 (TTY: 711).	Greek
آپ کو زبان کی معاونت کی خدمات اور اضافی امدادی آلات و توجہ فرمائیں: 0356-986-866-1 کال کریں۔ مفت فراہم کی جاتی ہیں۔ (TTY: 711)	Urdu
LƯU Ý: Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ và các dịch vụ hỗ trợ khác, miễn phí cho quý vị. Hãy gọi 1-866-986-0356 (TTY: 711).	Vietnamese
BEACHTEN SIE: Es stehen Ihnen kostenlose Sprachdienste, Hilfen und Dienstleistungen zur Verfügung. Rufen Sie 1-866-986-0356 (TTY: 711) an.	German

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注意：我们可为您提供免费的语言协助服务以及辅助工具和服务。请致电：1-866-986-0356（听力障碍电传：711）。	Chinese Mandarin
ध्यान दें: भाषा सहायता सेवाएँ, और सहायक सहायता एवं सेवाएँ आपके लिए निःशुल्क उपलब्ध हैं। 1-866-986-0356 (TTY: 711) पर कॉल करें।	Hindi
ATENÇÃO: Encontram-se disponíveis serviços de apoio linguístico gratuitos e ajudas e serviços auxiliares. Ligue para 1-866-986-0356 (TTY: 711).	Portuguese
注意：言語サポートサービスおよび補助器具・サービスを無料にてご利用いただけます。電話 1-866-986-0356（TTY: 711）。	Japanese

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CHAPTER 12:

Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

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 haven't 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's no limit to the number of benefit periods.

Biological Product – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that's manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Care Plan – A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and LTSS.

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Care Team – A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,400 for Part D covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay your deductible.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example \$10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't

Chapter 12 Definitions

covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the drugs covered by our plan.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is \$1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

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Durable Medical Equipment (DME) – Certain medical equipment that’s ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn’t on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you’re asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you’re asking for (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that’s approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn’t involve coverage or payment disputes.

Health Risk Assessment – A review of your medical history and current condition. It’s used to learn about your health and how it might change in the future.

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Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay is 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 after you pay your deductible (if you have one) and before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Integrated D-SNP – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of people eligible for both Medicare and Medicaid. These people are also known as full-benefit dually eligible people.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Institutional-Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

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Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for Medicare Part A and Part B premiums, and prescription drugs don't count toward the maximum out-of-pocket amount. (**Note:** Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum.)

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that's either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare UltraCare can cancel its plan enrollment and switch to another Medicare UltraCare or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug

Chapter 12 Definitions

plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

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 UltraCare 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 UltraCares also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare UltraCares 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 the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Drug coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare UltraCare isn't a Medigap policy.)

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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're filled at one of our network pharmacies.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare UltraCares and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

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Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

Preferred Provider Organization (PPO) plan – A Preferred Provider Organization plan is a Medicare UltraCare that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO 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.

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Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

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 based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that's designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

“Real-Time Benefit Tool” – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

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Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare UltraCare that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

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

MetroPlus UltraCare (HMO D-SNP) Member Services

Method	Member Services – Contact Information
Call	866.986.0356 Calls to this number are free. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.) Member Services also has free language interpreter services for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560.)
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 SHIP)

HIICAP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

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 Empire State Plaza, 5th Floor Albany, NY 12223
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, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



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